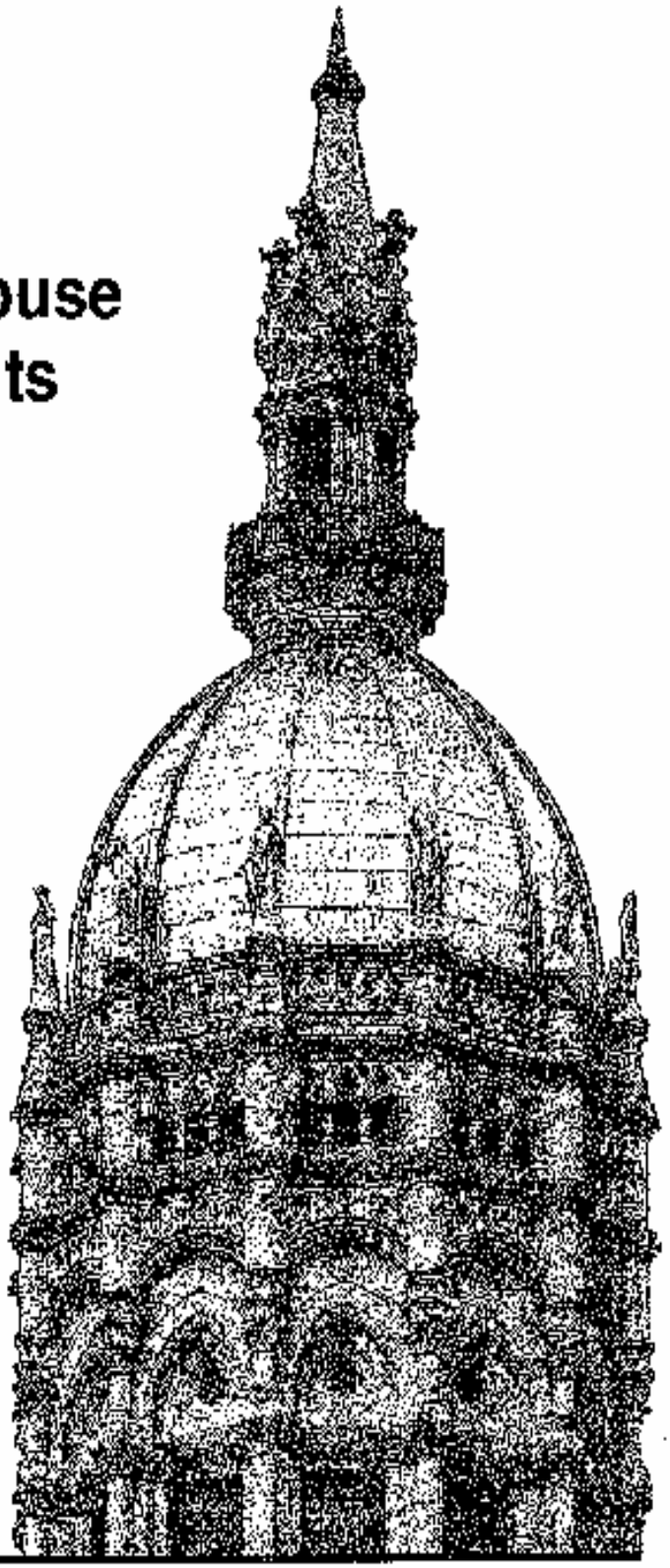
State Substance Abuse Treatment For Adults

DECEMBER 2008



PRI

Legislative Program Review and Investigations Committee

Connecticut General Assembly

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW
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Executive Summary

STATE SUBSTANCE ABUSE TREATMENT FOR ADULTS

Each year, Connecticut provides substance abuse treatment to thousands of adults with alcoholism and other drug addictions. Most are poor or medically indigent, and many are involved in the criminal justice system. State spending on treatment services for adults with substance use disorders totals over $200 million annually.

In April 2008, the Legislative Program Review and Investigations Committee directed its staff to study how the Department of Mental Health and Addiction Services (DMHAS) carries out its mission related to substance abuse treatment for adults, including how it coordinates and determines the effectiveness of all publicly funded services in the state. The study also incorporated the alcohol and drug treatment programs administered by the Department of Correction (DOC) and the Court Support Services Division (CSSD) of the Judicial Branch.

The Department of Mental Health and Addiction Services has been the state's lead substance abuse agency since 1995. However, publicly funded alcohol and drug abuse treatment for adults actually is provided through six different service delivery structures. These include:

- a network of private, primarily nonprofit providers funded by DMHAS to provide community-based substance abuse treatment;
- DMHAS-operated treatment facilities, which provide intensive residential and some outpatient care for the neediest adults with substance use disorders;
- the General Assistance Behavioral Health Program (GABHP) service system, a publicly managed behavioral health care program for adults covered by State-Administered General Assistance (SAGA) that is administered by DMHAS;
- the substance abuse treatment system for incarcerated adults operated directly by the Department of Correction;
- the continuum of treatment services the correction department funds for its parole clients with alcohol and drug abuse problems, which is provided primarily by the same private providers DMHAS funds; and
- the continuum of treatment services the Court Support Services Division funds for pre-trial diversion and adult probation clients with alcohol and drug abuse problems, which also is obtained primarily from the DMHAS-funded private provider network.

Study focus. The program review committee focused on determining how well DMHAS performs its lead agency functions of planning, coordinating, and overseeing the outcomes of all components of the state substance abuse treatment system. Efforts were made to identify the extent to which selected best practices known to contribute to effective substance abuse treatment were in place throughout the system. Key quality assurance and quality improvement activities of all three state agencies responsible for adult treatment services (DMHAS, DOC, and CSSD) also were reviewed. Where available, performance and outcome data for state-operated and funded alcohol and drug treatment programs were compiled and reviewed. The committee

additionally examined issues related to treatment access, including unmet need and possible duplication in service delivery.

Main findings. Based on its examination, the program review committee found the state system of substance abuse treatment for adults is decentralized and disjointed. Uniform policies and procedures are missing in many areas of practice and there are gaps in the existing continuum of services. DMHAS has been deficient in promoting consistent standards and the use of best practices across state agencies and private program providers. Further, under current law and regulation, providers of both mental health and substance abuse treatment are required to have two separate licenses, resulting in unnecessary and costly duplication and possible quality of care issues for clients.

The PRI review also showed monitoring of treatment quality across providers, levels of care, and funding sources is neither consistent nor comprehensive at present. A major impediment to effective quality assurance and quality improvement is the absence of formally established performance goals and benchmarks for state-operated and funded treatment programs. DMHAS, the lead agency for substance abuse, has no strategic planning process that begins with setting clearly defined, measurable outcomes for the publicly funded treatment system

In addition, while considerable amounts of outcome data and research on treatment effectiveness are produced, the available information is not aggregated, analyzed, and reported in ways that promote accountability and guide policy and funding decisions systemwide. DMHAS, in its lead agency role, does not regularly review the effectiveness of state-operated and funded programs and services to determine how they can be improved. Information sharing across state agencies and with the private provider network remains a challenge for both technical and administrative reasons.

The program review committee study found the effectiveness of various substance abuse treatment approaches is well documented by a substantial body of scientific research. It is clear that participation in quality treatment programs has positive results that include: reduced alcohol and drug use; improved functioning; minimized medical complications; and fewer negative social consequences (e.g., criminal activity). However, in Connecticut, access to treatment is restricted by limited capacity.

PRI research noted substantial unmet demand for services, particularly for residential treatment; reliable estimates of the number of adults in the state who are requesting but not receiving care, however, are lacking. In particular, the significant and special substance abuse treatment needs of adults within the criminal justice population need greater attention. At present, DMHAS does not assess demand, monitor service availability, or track the time spent in programs across the state alcohol and drug abuse treatment system.

Finally, the department could not provide PRI with any assessment of the financial viability of its network of private nonprofit providers, which delivers the bulk of state treatment services, or complete data on the costs associated with providing different levels of care. Over the last decade, stagnant state funding levels and rising operating costs have lead to serious fiscal

problems for many private programs, which could not be easily or economically replaced by state-operated services.

Committee recommendations. The program review committee made a total of 31 administrative and legislative recommendations intended to address the deficiencies found in the state substance abuse treatment system for adults. The proposed corrective actions center on three critical areas: increasing access to treatment; improving program monitoring and quality assurance throughout the system; and strengthening the lead agency role of the Department of Mental Health and Addiction Services.

Among the PRI committee's main proposals are statutory requirements for DMHAS to: assess and report on demand for treatment services; track and make public information about treatment availability; and create and regularly update, with input from other agencies and stakeholders, a comprehensive strategic state substance abuse plan. The department additionally would be required to issue a "report card" for the state treatment system and create and publish profiles for each treatment program operated or funded by the state. As lead state agency, DMHAS also should develop strategies for systemwide use of evidence-based practices and evaluate the long-term financial viability of the state's private substance abuse treatment provider network.

Each program review committee recommendation is listed in detail below. Taken together, they are aimed at enhancing the quality and delivery of state treatment services to achieve better outcomes for Connecticut adults with substance use disorders.

1) **DMHAS shall assess demand for substance abuse treatment services on a periodic basis through the coordination of wait list information or other methods to identify gaps and barriers to treatment services and report the results in the department's biennial report (p. 143).**

2) **DMHAS shall determine a method to track the availability of substance abuse treatment services and provide that information to the public through websites; a toll-free hotline, the statewide human service help line, 2-1-1 (formally Infoline); or other similar mechanisms (p. 143).**

3) **DMHAS shall develop and report on, in its biennial report, process measures that measure the length of:**
   - **time to receive substance abuse assessments and treatment through its provider network and for state-operated services; and**
   - **treatment services received, using the 90-day standard, on an episode of care basis (p. 143).**

4) **DOC should assess:**
   - **the costs and operational implications of transferring community service counselors to DOC facilities to expand**

intensive outpatient and residential treatment offerings in DOC facilities; and

in the absence of transferring community counselors, the cost savings that may accrue to treating additional inmates in DOC facilities rather than in residential treatment in the community while on parole (p. 144).

5) **The DOC parole division should improve its contract monitoring practice and quality assurance processes by including a periodic audit check of its contracted providers to ensure all contract requirements are being met and treatment services are being delivered appropriately (p. 148).**

6) **DMHAS should investigate, with CSSD, the DOC parole division, and DPH, the development of joint quality assurance and monitoring teams for substance abuse treatment facilities or a common approach for reviewing and checking similar areas of concern and coordinating such review efforts. Either activity should include the development of a corrective action plan summary of compliance issues identified regarding substance abuse treatment providers and the sharing of that information among all agencies (p. 148).**

7) **CSSD should expand its quality assurance process to include the division's other program models that contain a substance abuse treatment component (p. 148).**

8) **CSSD should further develop, and the DOC parole division should consider developing, a quality assurance process that assesses the work of probation and parole officers with regard to core practices that assist in reducing criminal behavior and enhancing offender motivation to change, especially for those offenders with a substance abuse problem (p. 148).**

9) **DMHAS should compile and analyze information about provider substance use testing procedures, create a uniform policy, and ensure that regular testing is performed and best practices are followed (p. 153) .**

10) **DMHAS shall establish a clear definition of research- and evidence-based practices and develop a strategy to encourage the use of such practices for substance abuse assessments and treatment, including program fidelity checks and measuring of the therapeutic alliance. The strategy shall be developed by January 1, 2010 (p. 153).**

11) **DMHAS should collect and report data on the number of substance abuse clients who receive services to support their recovery and any related outcome information (p. 153).**

12) **The DOC parole division should ensure that all treatment information is considered when referring clients for additional substance abuse treatment, including the treatment received while in DOC facilities and any discharge planning developed by**

the Addiction Services Unit. The division should ensure that all referrals to residential treatment are made appropriately (p. 153) .

13) **The Board of Pardons and Paroles should consider having the evidence-based assessment tool called the Level of Service Inventory administered by parole officers before a final decision is made by the board regarding parole eligibility and conditions of parole (p. 153).**

14) **DOC and CSSD shall ensure that all substance abuse treatment providers are properly licensed as required by law (p. 153).**

15) **DMHAS shall develop a strategy to encourage the development of licensed or credentialed staff in providing clinical services within all state-funded and -operated substance abuse treatment programs. The strategy shall consider a long-term phase-in of such a requirement. The strategy shall be developed by January 1, 2010 (p. 153) .**

16) **DMHAS shall compile a profile of each substance abuse treatment provider that receives state funding. This provider profile shall be updated on an annual basis and be maintained on the department's website. Both DMHAS and DOC also shall create a similar profile for the programs they operate. The profile shall include:**
    - **client populations served;**
    - **language competence of staff;**
    - **types of care available and the number served at each level of care;**
    - **extent to which services are evidence-based or not;**
    - **accreditation status of the provider;**
    - **client survey results;**
    - **the percent of employees who are licensed or credentialed who perform assessment, treatment plan development, and treatment delivery services; and**
    - **treatment completion rates by level of service, average wait times for treatment services, and outcome information, including the federally required National Outcome Measurement System data, and any other information DMHAS deems relevant (pp. 153-154).**

17) **CSSD and DOC should calculate completion rates for those clients enrolled in their substance abuse treatment programs. CSSD and DOC should benchmark their completion rates against programs offered by other similar criminal justice and correctional agencies. In addition, DOC should evaluate whether its contracted community private providers produced better completion rates and outcomes than offenders on parole and receiving services from DOC (p. 156).**

18) **DMHAS, in conjunction with CSSD, should conduct an evaluation of the effectiveness of PAES and PDEP programs, in terms of their impact on participant**

substance use and criminal justice involvement. The agencies also should develop outcome measures for both programs that are reported, at a minimum, in the DMHAS biennial report, beginning in 2010 (p. 157)

19) **DMHAS should develop and review the performance and outcome information related to the state's methadone maintenance and other opioid replacement treatment programs by July 1, 2010. The information should be summarized and reported on the agency's website and in the department's biennial report. At a minimum, it should include: how long people remain in treatment; whether providers are in compliance with all state and federal standards; and what improvement clients have experienced in their substance use and quality of life because of the treatment they received (p. 157).**

20) **The annual State of Connecticut Recidivism Study generated by the Criminal Justice Policy and Planning Division of the Office of Policy and Management should evaluate and report the effects of substance abuse treatment received by offenders on subsequent criminal justice involvement (p. 157).**

21) **DMHAS, as the lead state substance abuse agency, should expand and strengthen its role in developing, gathering, analyzing, and reporting outcome measures regarding the effectiveness of the state's substance abuse treatment system (p. 157).**

22) **DOC should conduct an assessment of its management information system to determine how it could better meet the department's research and management needs (p. 159).**

23) **Current statutory provisions for a statewide substance abuse plan shall be repealed and replaced with a requirement for a strategic planning process for the state substance abuse treatment system for adults that is overseen by DMHAS (p. 163).**

Beginning in 2009, the department shall prepare and annually update a three-year strategic plan for providing state treatment and recovery support services to adults with substance use disorders. The plan shall be based on a mission statement, a vision statement, and goals for the state treatment system, including all state-funded and state-operated services, that are developed by DMHAS, in consultation with: its regional action councils; consumers and their families representing all client populations, including those involved in the criminal justice system; treatment providers; and other stakeholders.

The strategic state substance abuse plan shall outline the action steps, timeframe, and resources needed to address the goals developed with stakeholders. At a minimum, the plan shall address the following areas:

- **access to services, prior to and following admission to treatment;**

- **comprehensive assessment of the needs of those requesting treatment, including individuals with co-occurring conditions;**
- **quality of treatment services and promotion of best practices, including evidence- and research-based practices and models;**
- **provision of an appropriate array of treatment and recovery services along a sustained continuum of care;**
- **outcomes of specific treatment and recovery services and of the overall system of care; and**
- **department policies and guidelines concerning recovery-oriented care.**

The plan also shall define measures and set benchmarks for assessing and reporting on progress in achieving the plan goals, statewide and for each state-operated program. These should include but not be limited to: timeliness (e.g., portion of clients admitted to treatment within one week after referral); penetration rates (percent of those needing treatment who receive it); completion rates; connection-to-care rates; length of treatment episode (e.g., portion of clients receiving treatment of 90 days or more); and rates of client improvement regarding substance use, employment status, stable housing, criminal activity, and relationships with family and community.

The first three-year plan shall be completed by July 1, 2010. DMHAS shall submit final drafts of the initial plan and its annual updates to the state Alcohol and Drug Policy Council for review and comment. Progress in achieving the plan's goals shall be summarized in the department's biennial report on substance use that is submitted to the legislature and the council under C.G.S. Section 17a-45 (pp. 163-164).

24) **Provisions of the community reentry strategy developed by the Criminal Justice Policy and Planning Division regarding substance abuse treatment and recovery services needs of the offender population shall be incorporated within the state strategic plan.**

Further, DMHAS shall consult with the Criminal Justice Policy Advisory Commission in developing goals related to the special treatment and recovery service needs of adults involved in the criminal justice system, as well as strategies for meeting them, for the new state substance abuse plan. A work group composed of staff from CSSD, DOC Addiction Services, DOC Parole, and the DMHAS Forensic Services Division, and representatives of private nonprofit providers of adult substance abuse treatment services, should be formed to assist with this process (p. 164).

25) **DMHAS shall conduct a financial viability assessment of its private provider network. This assessment should estimate the extent to which the community**

providers have the ability to appropriately meet their clients' needs and their mission in a sustainable way over the next five to ten years (p. 165).

26) The statutes shall be amended to establish clearly that DMHAS is the state lead agency for substance abuse (p. 169).

27) DMHAS should create and lead an interagency workgroup, composed of its own staff responsible for fiscal, contracting, and provider monitoring functions, as well as staff from other state agencies that fund and/or oversee substance abuse treatment services, including CSSD, DOC, and DPH, to study and address such matters as:

- **rules and regulations that are at odds with best care practices (e.g., appointments on separate days) and needless duplication of effort (e.g. repetitive financial forms);**

- **a standard plan of care so no matter what "door" a person comes in for treatment, there will be a consistent approach to developing the care plan, each plan will address a full continuum of services (from detoxification, if needed, to aftercare) and it will follow the client through the publicly funded system;**

- **better sharing of data, including regular distribution of DMHAS monthly and semi annual provider performance reports and profiles to CSSD and DOC; and**

- **ways to track and report on connection to services and treatment outcomes for DOC and CSSD clients with substance use disorders following discharge from the criminal justice system (pp. 169-170).**

28) DMHAS should begin working closely with the Department of Public Health to have updated substance abuse treatment regulations and the new combined license for dual behavioral health care providers in place by July 1, 2010 (p. 170).

29) The department also should conduct, with assistance from DOC and CSSD, a formal analysis of the costs and benefits of the collaborative contracting project to determine its impact on: standardizing rates paid by participating agencies; reducing administrative expenses of providers; and improving access to, and utilization of, available residential treatment resources (p. 170).

30) DMHAS should restructure its existing staff resources allocated to planning, monitoring, and evaluation to create a centralized unit responsible for comprehensive strategic planning and quality improvement. It should also serve as the department's best practices unit, identifying effective treatment approaches and

performing a clearinghouse function on policies, programs, and activities followed by Connecticut programs with good outcomes. Further, it should be a central repository for all state agency internal and external research products on treatment effectiveness (p. 170).

31) **DMHAS shall prepare a "report card" for the publicly funded substance abuse treatment system that addresses, but is not limited to, the following areas: access to treatment; quality and appropriateness of treatment; treatment outcomes, including measures of abstinence and reduced substance use, as well as quality of life improvements related to employment, living arrangement, criminal justice involvement, family and community support; and client satisfaction. At a minimum, the report card should be posted on the agency website and included in the department's biennial report (p. 170.).**

Introduction

State Substance Abuse Treatment for Adults

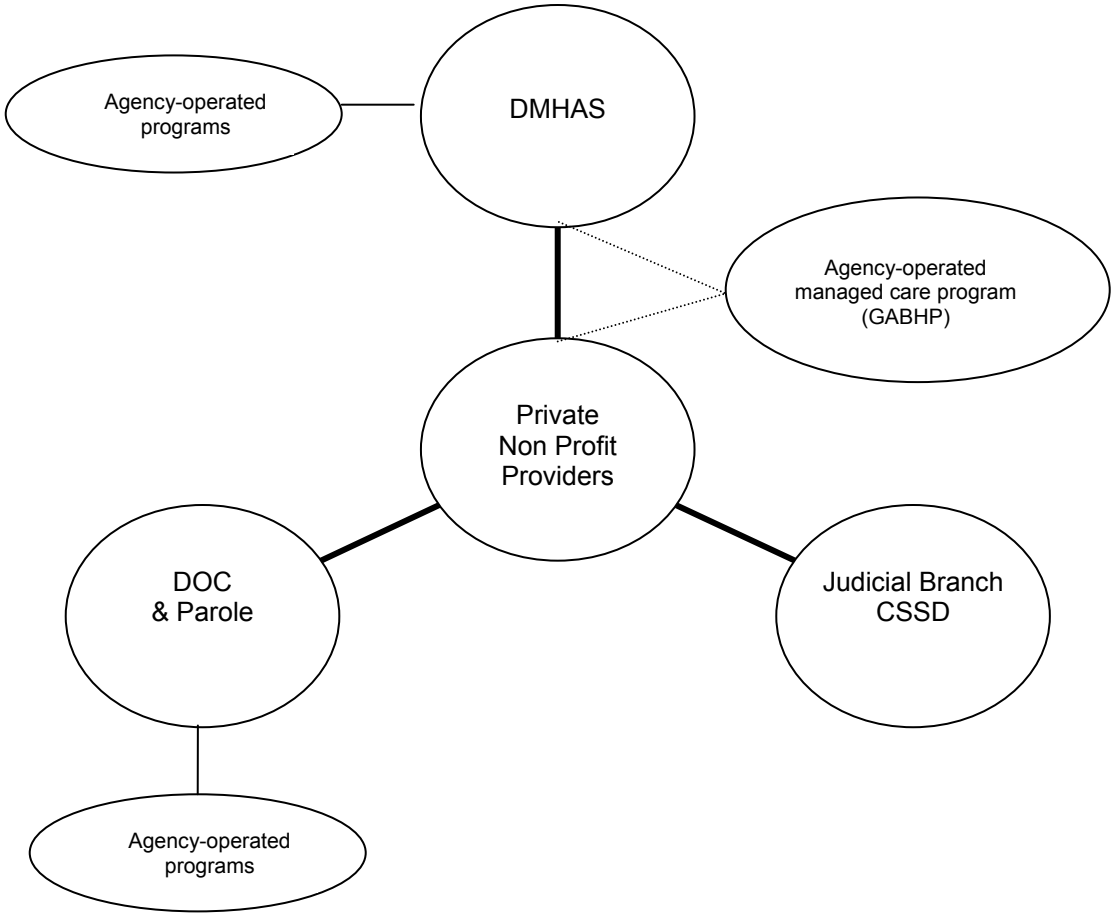
Each year, thousands of individuals with alcohol and drug problems are served by Connecticut's publicly funded substance abuse treatment system. In total, the state spends more than $200 million a year providing treatment services to adults with alcoholism and other drug addictions, most of whom are poor or medically indigent.

In April 2008, the Legislative Program Review and Investigations Committee directed its staff to study how the Department of Mental Health and Addiction Services (DMHAS) carries out its mission related to alcohol and drug abuse treatment for adults, including how it coordinates and determines the effectiveness of all publicly funded services in the state. The study also included an examination of the adult substance treatment programs and services administered the Department of Correction (DOC) and the Court Support Services Division (CSSD) of the Judicial Branch. Services for those under age 18, which are overseen by the Department of Children and Families (DCF), were not included within the scope of this study

The Department of Mental Health and Addiction Services has been the state's lead agency for substance abuse since 1995, when responsibilities for the community-based alcohol and drug treatment system for adults, and for the inpatient programs operated by the former mental health department, were merged within one agency. However, as the PRI study revealed, publicly funded treatment for adults with substance use disorders actually is provided through six different service delivery and/or funding structures. The components of the state substance abuse treatment system, which are illustrated in Figure 1, include:

- the private, primarily nonprofit provider network funded by DMHAS to provide community-based substance abuse treatment;
- the state-operated treatment facilities, which provide intensive residential and some outpatient care for the neediest adults with substance use disorders;
- the General Assistance Behavioral Health Program (GABHP) system, a publicly managed behavioral health care program for adults covered by State-Administered General Assistance that is administered by DMHAS;
- the substance abuse treatment system for incarcerated adults operated directly by the Department of Correction;
- the continuum of treatment services the correction department funds for its parole clients with alcohol and drug abuse problems, which are provided primarily by the same providers that DMHAS funds; and
- the continuum of treatment services the Court Support Services Division funds for pretrial diversion and adult probation clients with alcohol and drug abuse problems, which also are obtained primarily from the DMHAS-funded provider network.

Figure 1. State Substance Abuse Treatment System for Adults



Study Scope

The size and complexity of state administration and funding for adult substance abuse treatment prevented the committee from examining in detail the specific programs and processes of all six system components within the study timeframe. Research efforts focused on determining how well DMHAS is carrying out its critical lead agency functions to plan, coordinate, and oversee an effective treatment system for adults. However, key quality assurance and quality improvement activities of all three agencies were reviewed and available performance and outcome data relating to the effectiveness of agency substance abuse treatment programs were compiled.

In addition, the committee study tried to identify the extent to which best practices known to contribute to effective substance abuse treatment were in place throughout the state service delivery system. Issues related to access to assessment and treatment services, including unmet needs and duplication among agencies, also were examined.

Research Methods

Initially, program review committee staff work concentrated on three main tasks:

- reviewing available data and background information about the nature and prevalence of substance abuse and the basis for current treatment models;
- gathering and assessing research findings about the best practices associated with effective substance abuse treatment for adults; and
- identifying and describing the major programs and services that make up the state treatment system, as well as the main steps in each state agency's treatment process.

PRI staff collected existing descriptive data on programs, services, and clients from each major state provider of adult substance abuse treatment services – DMHAS, the Judicial Branch (primarily the Court Support Services Division), and DOC, for both its institutional and community-based (parole) populations. To develop additional information about the state treatment system, staff also: conducted interviews with management and direct care staff at each agency; visited treatment programs at several DOC facilities and one parole office; observed CSSD staff at work with clients at the Hartford Superior Court; and met with DMHAS substance abuse treatment personnel during a tour of Connecticut Valley Hospital.

Multiple meetings were held with members of the organizations that represent private nonprofit agencies that provide substance abuse treatment services to state agencies. Program review staff also made field visits to private provider programs located in Hartford, New Haven, and Middletown. In addition, staff interviewed a number of treatment professionals, experts, and stakeholders, including members of DMHAS regional advisory councils, to obtain their views on strengths and weaknesses of the current service system for adults with substance use disorders. The program review committee also held an informational public hearing at the Legislative Office Building in Hartford to receive input and public comment regarding the state substance abuse treatment system for adults on October 2, 2008.

Report Organization

Background information about the nature of substance abuse and the prevalence and rate of alcohol and drug abuse problems nationally, and in Connecticut, is presented in Chapter I. It also provides data on treatment services and outlines the wide array of programs and services aimed at treating substance abuse. Current research about treatment effectiveness also is highlighted in Chapter I.

Chapter II provides an overview of Connecticut's publicly funded substance abuse treatment system, including a description of DMHAS's role as the state lead agency for substance abuse prevention and treatment. The next two chapters describe the substance abuse treatment activities for adults involved in the criminal justice system that are carried out by CSSD (Chapter III) and DOC (Chapter IV).

A discussion of key monitoring activities related to substance abuse treatment that are carried out by all three agencies is contained in Chapter V. It focuses on the presence (or absence) of selected best practices associated with effective treatment outcomes in each agency's quality assurance and improvement policies and procedures. Committee findings and recommendations aimed at improving the effectiveness of the state's system for treating adults with substance use disorders are presented in the final chapter, Chapter VI.

Agency response. It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comment on committee findings and recommendations prior to publication of the final report. Written responses were solicited from the state Departments of Mental Health and Addiction Services and Correction, the Judicial Branch, the Board of Pardons and Paroles (BOPP), and the Office of Policy and Management (OPM). DMHAS, DOC, and the Judical Branch submitted formal comments, which are presented in Appendix G. Technical clarifications provided by these agencies also were incorporated in the final committee report by PRI staff as appropriate.

Chapter I

Background: Substance Abuse, Prevalence, and Treatment

This chapter provides an overview of: the nature of substance abuse, dependence, and addiction; its prevalence in the population; and the broad range of treatment approaches for substance use disorders. Substance abuse treatment trends, as well as comparisons of treatment services, and client characteristics at the state and national level, also are examined. Finally, this chapter includes a summary of current scientific research regarding the overall effectiveness of substance abuse treatment and available information from federal studies on the relative cost-effectiveness of treatment.

The Nature of Substance Abuse, Dependence, and Addiction

Substance abuse refers to the misuse of alcohol, tobacco, and other legal and illegal drugs. In general, individuals are considered to have a substance abuse problem when there is a pattern of alcohol or other drug use causing harmful consequences (e.g., missing work or school, driving while intoxicated, getting arrested, and fighting with family). In its most severe form, described below, it is defined as dependence or commonly referred to as addiction. A growing recognition of addiction as a chronic, relapsing illness needing continual care has influenced substance abuse policies and treatment approaches at the state and federal level in recent years.

Brain disease. Addiction is a complex phenomenon. The key distinguishing characteristics of addiction include uncontrollable and compulsive drug craving and use even in the face of damaging health and social consequences. The concept of addiction has evolved over time and away from the notion that drug addiction results from a failure of will. Although the initial use of drugs is voluntary, current research has identified addiction as a chronic but treatable brain disease. The repeated abuse of drugs leads to fundamental changes in the structure and function of the brain. These modifications to the brain can persist for many years even after an individual stops using drugs.

Generally, addiction occurs over a period of time. Many people start as casual drug and alcohol users and stay that way. However, others move from experimental use to regular or risky use to addictive and uncontrollable use. No single factor can predict if a person will become addicted to drugs or alcohol. The interaction of biological and environmental factors influences the progression to addiction and makes treatment challenging. The identified risk factors for addiction include a person's genetic makeup, mental illness, social environment, childhood trauma, and the early use of drugs. Stress is also associated with addiction. Experts have pointed out that for most people addiction is at the end of a long series of substance use problems and it is important to treat those problems at the earliest stages. Contrary to popular mythology, a person does not need to hit rock bottom for treatment to be effective.

Criteria. There are established criteria that determine when substance use has developed into dependence. Connecticut state statutes[1] define alcohol dependence and drug dependence in

[1] C.G.S. Sec. 17a-680

terms of the psychiatric profession's manual for diagnosing mental health and substance use disorders.[2] The criteria are presented in Table I-1. Essentially, a clinical diagnosis of dependence requires the presence of three or more factors, over a 12-month time period, from a group that includes five behavioral factors (like being unable to stop alcohol or drug use or exceeding self-imposed limits) and two physiological factors, which include symptoms of tolerance and/or withdrawal.

Table I-1. American Psychiatric Association Criteria for Substance Dependence

Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following factors, listed below, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the substance.
    b. The same (or a closely related) substance is taken to relieve or avoid symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. The person experiences a persistent desire (or unsuccessful efforts) to reduce or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Source: American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Text Revision

Co-occurring disorders. Further complicating the understanding and treatment of addiction is the prevalence of co-occurring mental health disorders. A significant portion of

[2] The American Psychiatric Association, "Diagnostic and Statistical Manual of Mental Disorders." The most recent is the 4th edition, May 2000, Text Revision (DSM-IV, TR).

people with substance use problems also have other mental illnesses, such as attention deficit hyperactive disorder, bipolar disorder, depression, post-traumatic distress disorder, and schizophrenia. Some people with untreated mental health problems start using drugs or alcohol as a way to self-medicate, while others develop symptoms of mental illness after using drugs. The National Institute of Mental Health has provided some estimates (Table I-2) of the increased risk for substance abuse given a particular psychiatric disorder. Concerns are raised when health care practitioners treat one disorder without treating or being aware of the other. The best chance at success and recovery requires that both disorders be treated at the same time. If not, both disorders often get worse. In addition, individuals with addictions also tend to suffer from one or more accompanying physical medical issues, including lung and cardiovascular disease, stroke, and injection-related illness such as HIV/AIDS and hepatitis.

Table I-2. Increased Risk for Substance Abuse Based on Psychiatric Disorder

Psychiatric Disorder	Increased Risk For Substance Abuse
Antisocial personality disorder	15.5%
Manic episode	14.5
Schizophrenia	10.1
Panic disorder	4.3
Major depressive episode	4.1
Obsessive-compulsive disorder	3.4
Phobias	2.4

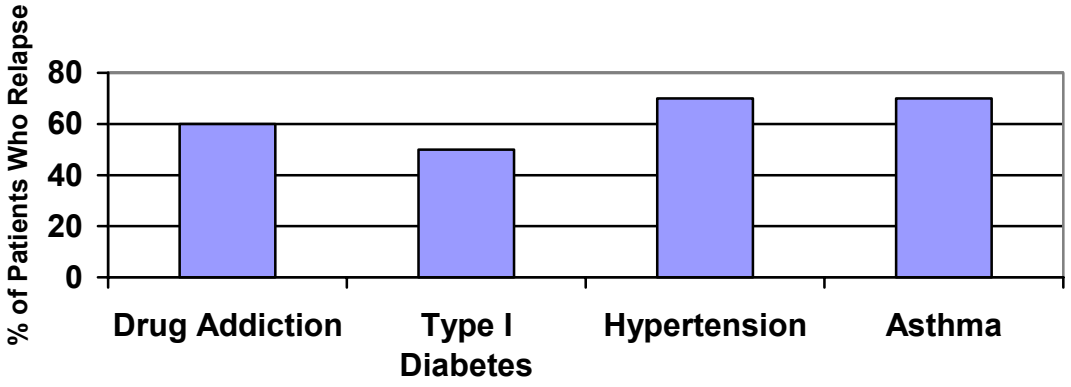
Source: National Institute of Mental Health

Chronic illness. Increasingly, drug and alcohol addiction is described as a chronic medical illness. Drug addiction shares many characteristics of chronic illnesses, such as hypertension, diabetes, and atherosclerosis. These illnesses can begin with unhealthy voluntary behaviors (e.g., poor nutrition, lack of exercise) that cause biological changes and result in a chronic lifelong condition. These diseases are largely incurable but can be effectively treated and managed through medications and lifestyle changes. The implications for the acceptance of addiction as a chronic illness can be far reaching. Drug dependence has often been treated as an acute illness calling for brief interventions. However, a chronic condition requires long-term care strategies for the management of medication and continued behavioral monitoring to ensure long-lasting benefits.

Relapse. Like other chronic illnesses, people who are addicted often have relapses or a return to the abuse of drugs and alcohol after a period of abstinence. Paradoxically, a relapse episode is not viewed as a failure by many practitioners in the field. Rather a relapse is thought to be a sign that treatment needs to be reinstated or adjusted to help the individual recover. For many, successful treatment may involve several interventions and attempts at abstinence. As shown in Figure I-1, researchers have demonstrated that the rate of relapse among those addicted

to drugs (between 40 to 60 percent) is similar to other chronic diseases.[3] (The study cited in the figure provided a range of relapse for each illness. Just the high end of the range for each is presented.) The road to recovery from drug and alcohol addiction often includes relapse.

Figure I-1. Relapse Rates for Drug Addiction and Other Chronic Illnesses



Source of Data: McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA 284(13):1689-1695, 2000.

Relapse is possible regardless of how long a person has been abstinent. This is because an addicted person can be affected by certain triggers that create cravings and possibly lead to substance abuse. Triggers are warning signs that relate to changes in behavior, attitudes, feelings, and thoughts. These changes can be initiated by various things that remind individuals of their past drug use, like being in an old neighborhood where an individual abused drugs or a conflict with a spouse. The point for someone in recovery is to recognize the warning signs that precede the relapse and develop a coping strategy to prevent it. Many practitioners maintain that as long as the person in recovery is making efforts to maintain sobriety and adhere to treatment, progress in the process is being made.

Prevalence and Treatment Trends

A variety of state and federal data sources were combined and analyzed by PRI staff to obtain an understanding of the prevalence of psychoactive substance use, abuse, and dependence in Connecticut.[4] In addition, the trends in access to and use of treatment services in the state were examined. In summary, staff analysis of the information presented in this section shows:

- Connecticut has a higher rate of alcohol use, binge drinking, and illicit drug use than the national average. Connecticut's rate of substance abuse or dependence (10.1 percent) is higher than the nation as a whole (9.2 percent) and appears somewhat higher than it was in 2002 (8.6 percent).

[3] Relapse for other chronic diseases means that a patient experiences a recurrence of symptoms to the point where he or she requires additional medical care to reestablish symptom remission because of a lack of adherence to medical schedules or behavioral or diet changes.

[4] Psyhcoactive refers to substances that have a profound or significant effect on mental processes

- While marijuana is the most frequently used illicit drug in Connecticut and alcohol is the most frequently abused substance, the biggest problem substances for adults at time of admission to treatment are heroin and other opiates, followed by alcohol, cocaine, and marijuana.

- The non-medical use of prescription drugs (especially synthetic opiates) has been increasing in Connecticut. Opiates, particularly heroin, are more often the reason for treatment, and stimulants (like methamphetamine) are less often the primary problem at admission than in the nation as a whole.

- The number of adults in Connecticut age 18 and older estimated to have a current need for treatment for substance abuse or dependence is 268,000. Rates of access to substance abuse treatment vary among different state agency populations and DMHAS estimates many groups are underserved. It appears less than half of those involved in the criminal justice system needing treatment are admitted to services and access can vary by race.

- The population groups identified with a greater *risk of substance dependence* were males, young adults, non-Hispanics, and those with less than a high school education. However, clients *admitted to treatment* are older with an average age at time of admission of 35.5 years.

- Detoxification and outpatient services, both regular and intensive, are the most used types of treatment for substance abuse in Connecticut followed by the various types of residential rehabilitation and opioid replacement therapies (ORT). Connecticut has a higher use of detoxification and ORT than does the nation as a whole.

- Many adults admitted for substance abuse treatment in Connecticut are served by other state agencies, with the largest percentages involved with social service programs (e.g., Food Stamps, State Administered General Assistance, Medicaid) and with the criminal justice system.

Prevalence and abuse. In order to analyze the prevalence of substance use and the rate of substance abuse and dependence within the state, PRI staff used two data sets. *The National Survey on Drug Use and Health* (NSDUH) was analyzed to examine trends over time and to compare Connecticut to the national and regional experience. The NSDUH is the primary source of statistical information on the use of licit and illicit substances by the U.S. civilian population age 12 and older. It is conducted by the federal Substance Abuse and Mental Health Services Administration, Office of Applied Studies, on an annual basis. The national survey represents the best data currently available.

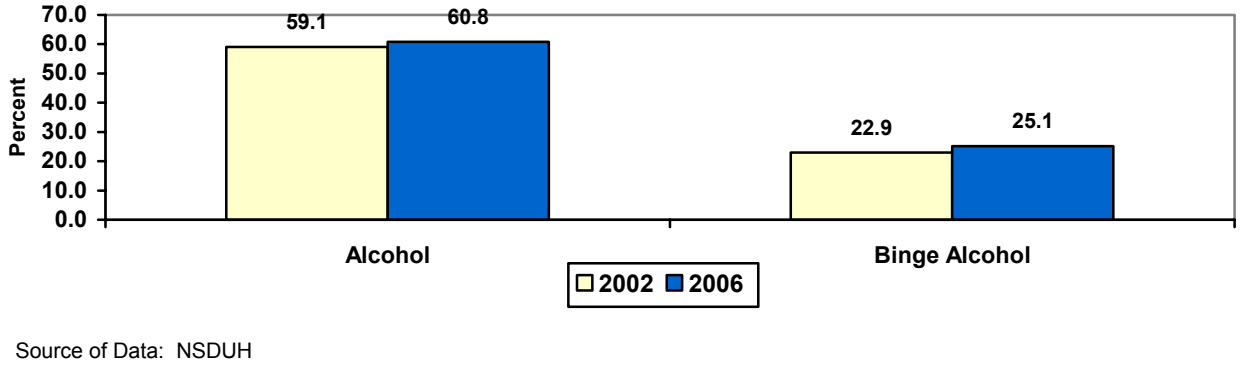
Most of the statistics presented in the NSDUH aggregate adult and adolescent (i.e., ages 12 to 18) populations. The latest edition contains substance use and abuse data for 2006.[5] It should be noted that the sample size of the NSDUH may affect the comparisons of differences between years. The difference between years (2002 versus 2006, for example) has not been tested for statistical significance.

To obtain a more detailed understanding of the demographics of substance use and abuse in Connecticut, the DMHAS-sponsored *Substance Abuse Treatment Need and Demand in Connecticut: 2003 Adult Household Survey* (AHS) is also used in this report. Data collection for this survey was conducted by telephone between July 2003 and March 2004 and is the most recent detailed information available about Connecticut citizens age 18 and older.

Alcohol. As defined in the national survey, "alcohol use in the past month" is the consumption of at least one drink during the past 30 days (including binge use). Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the 30 days prior to the survey.[6]

Alcohol is the most commonly used psychoactive substance in the United States. Nationally, about half (51.4 percent) of Americans age 12 or older reported being current (past month) drinkers of alcohol in 2006 and the same percent reported current use in 2002. Connecticut's use of alcohol is higher than the national average with past month use of alcohol at 60.8 percent in 2006. As Figure I-2 shows, the rate of use in Connecticut has not significantly changed in the last five years, as has been the case nationally.

Figure I-2. Alcohol Use in Past Month and Binge Alcohol Use in Connecticut - Age 12 or Older, 2002 & 2006



Source of Data: NSDUH

Nationally, 22.8 percent of all persons age 12 or older participated in binge use of alcohol in the past month in 2006. This rate remained relatively unchanged from 2002. Binge use in Connecticut (25.1 percent) was slightly higher than the national average in 2006 and appears higher since 2002 (22.9 percent).

[5] The annual estimates are actually based on a two-year moving average of NSDUH data in order to enhance the precision for states with smaller samples.

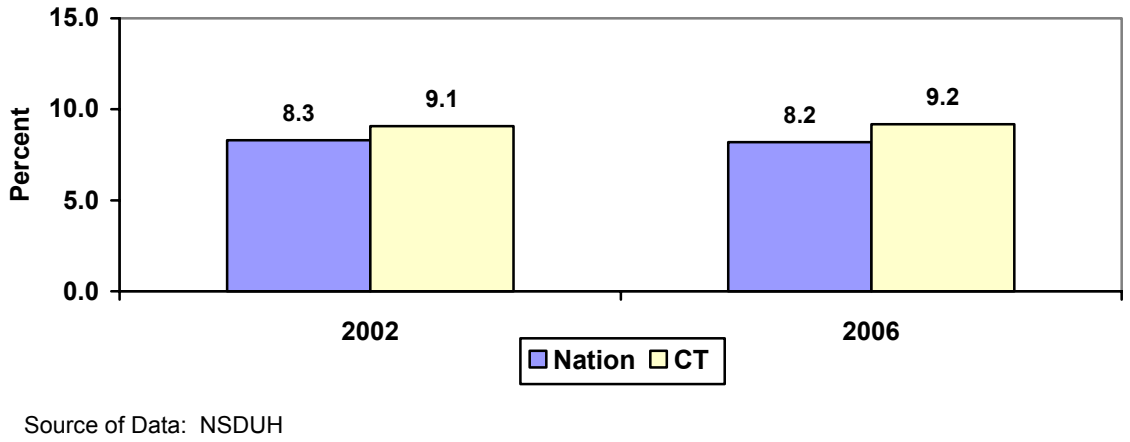
[6] A "drink" is defined as a can or bottle of beer, a glass of wine or a wine cooler, a shot of liquor, or a mixed drink with liquor in it. Respondents are asked to exclude occasions when only a sip or two is consumed from a drink.

According to the Connecticut 2003 Adult Household Survey, alcohol use was most likely to be reported by men, adults age 35 to 44 years old, non-Hispanics, Whites, those with a college education or more, high income earners, and those employed full time.[7]

Illicit Drugs. The national survey includes information on nine different categories of illicit drug use: marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives.

In 2006, as Figure I-3 shows, 8.2 percent of the U.S. population age 12 or older had used an illicit drug in the past month, compared to 9.2 percent in Connecticut. States in the Northeast region had a higher average rate of illicit drug use (8.9 percent) than the national average.[8] For both the nation and Connecticut, the rate of illicit drug use has shown no change since 2002.

Figure I-3. Use of Any Illicit Drug in the Past Month Age 12 or Older, Nation vs. CT, 2002 & 2006



Source of Data: NSDUH

Marijuana is the most frequently used illicit drug both nationally and in Connecticut. As shown in Figure I-4, marijuana was used in the past month by 7.6 percent of Connecticut citizens in 2006 and 6.3 percent in 2002. Nationally, in 2006, 6.0 percent of all persons aged 12 or older reported marijuana use in the past month.

The 2003 Connecticut Adult Household Survey noted that higher rates of marijuana use were associated with being male, a young adult aged 18 to 25, non-Hispanic, Black, less than high school education, lower income, unemployed, and never being married.

The national use of illicit drugs *other than marijuana* in the past month for persons age 12 or older was 3.8 percent in 2006. As presented in Figure I-4, Connecticut's use of illicit drugs other than marijuana was 3.9 percent in 2006.

[7] The AHS surveyed adults age 18 and over, while the NSDUH surveyed people age 12 and older.
[8] Northeast Region includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

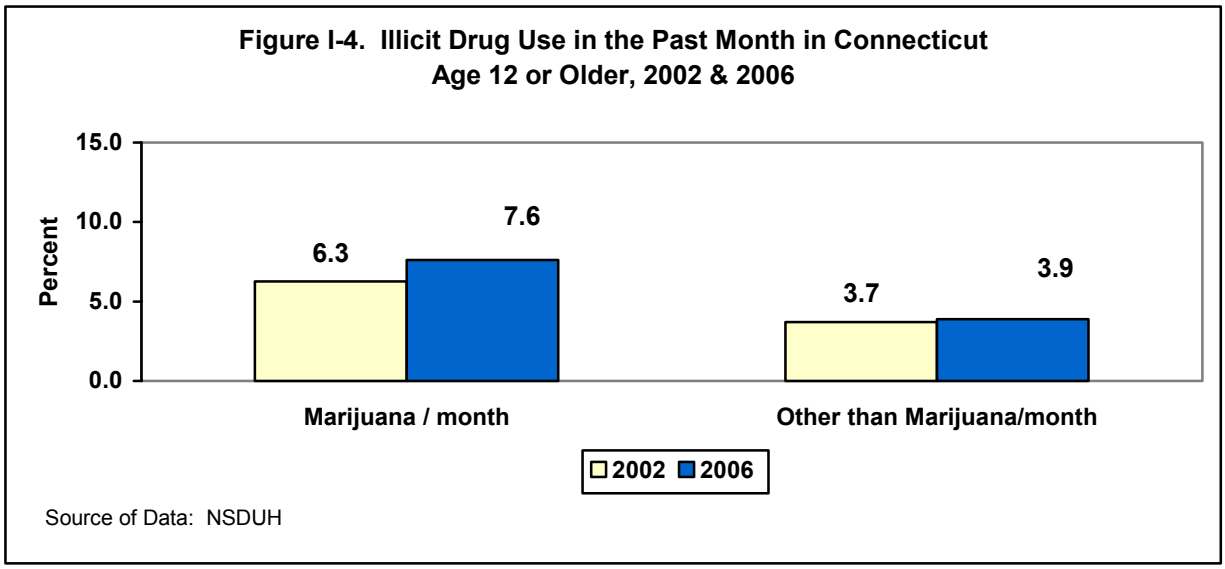
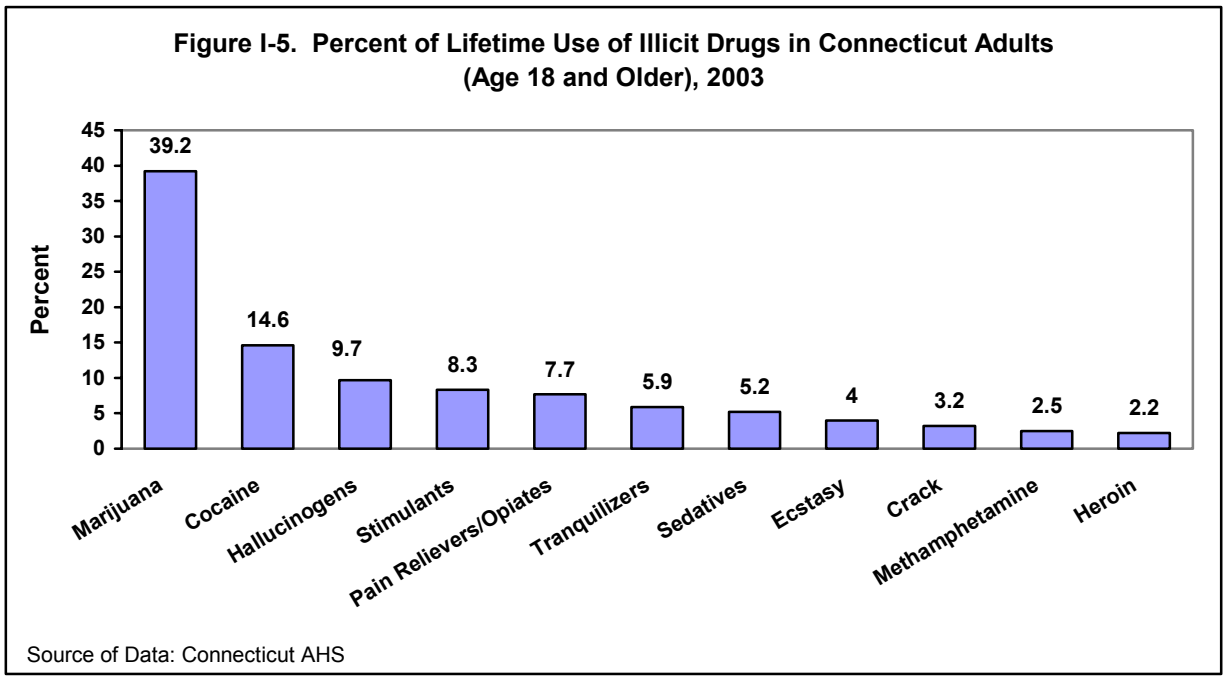


Figure I-IV also shows an apparent increase (from 6.3 to 7.6 percent) in the use of marijuana (in the last month) between 2002 and 2006. There appears to have been little change in the overall use of illicit drugs other than marijuana in Connecticut over that same time period (about 4 percent).

The 2003 Connecticut Adult Household Survey reports on the lifetime use of various illicit drugs among Connecticut adults.[9] Figure I-5 shows that marijuana is by far the most used illicit drug followed by cocaine and hallucinogens.



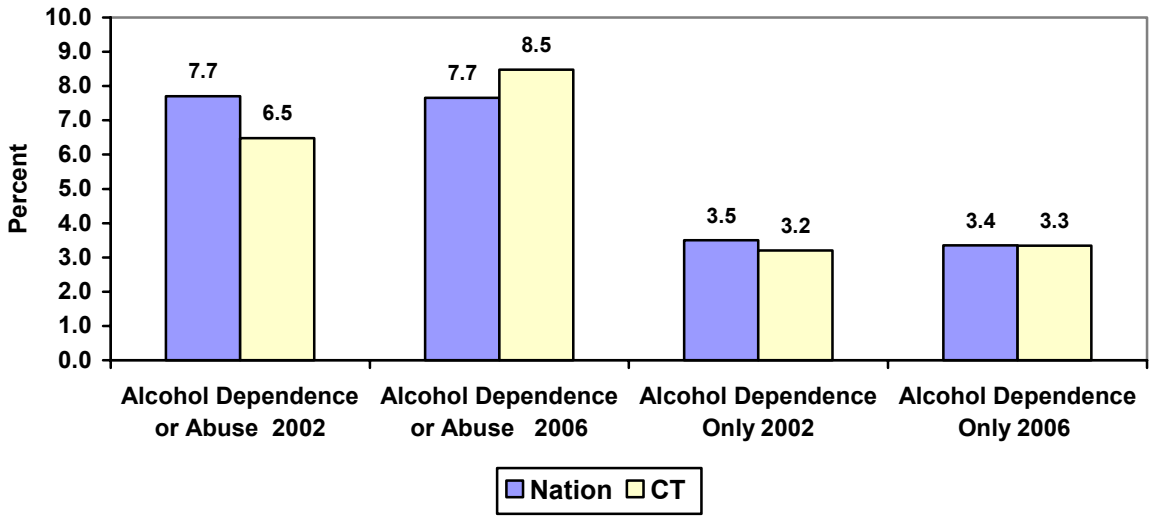
[9] Lifetime use refers to using the substance at least once over the course of one's life.

The non-medical use of prescription medicine, and in particular pain medication, in Connecticut by individuals age 12 and older in the last year appears to have risen according to the NSDUH survey -- from 4.0 percent in 2003 to 5.2 percent in 2006. The national estimate for the non-medical use of prescription medicine in 2003 was 4.8 percent, and in 2006 it was 5.0 percent.

Substance abuse and dependence. The NSDUH contains a series of questions to assess the prevalence of substance use disorders (i.e., dependence on or abuse of a substance) in the past 12 months. Substances include both alcohol and illicit drugs. These questions are used to classify persons as being dependent on or abusing specific substances. As discussed earlier, dependence reflects a more severe substance problem than abuse.

Alcohol dependence or abuse. Nationally in 2006, 7.7 percent of the population age 12 or older was classified with dependence on or abuse of alcohol in the past year. As illustrated in Figure I-6, Connecticut's rate (8.5 percent) was higher than the national rate of alcohol abuse or dependence in 2006. Connecticut's rate of abuse or dependence was lower in 2002 (6.5 percent), while the nation's total was unchanged. In 2006, persons age 18 to 25 had the highest rate of alcohol dependence or abuse (17.6 percent) in the nation and in Connecticut (23.1 percent).

Figure I-6. Alcohol Dependence or Abuse in Past Year Age 12 or Older, Nation vs CT 2002 & 2006

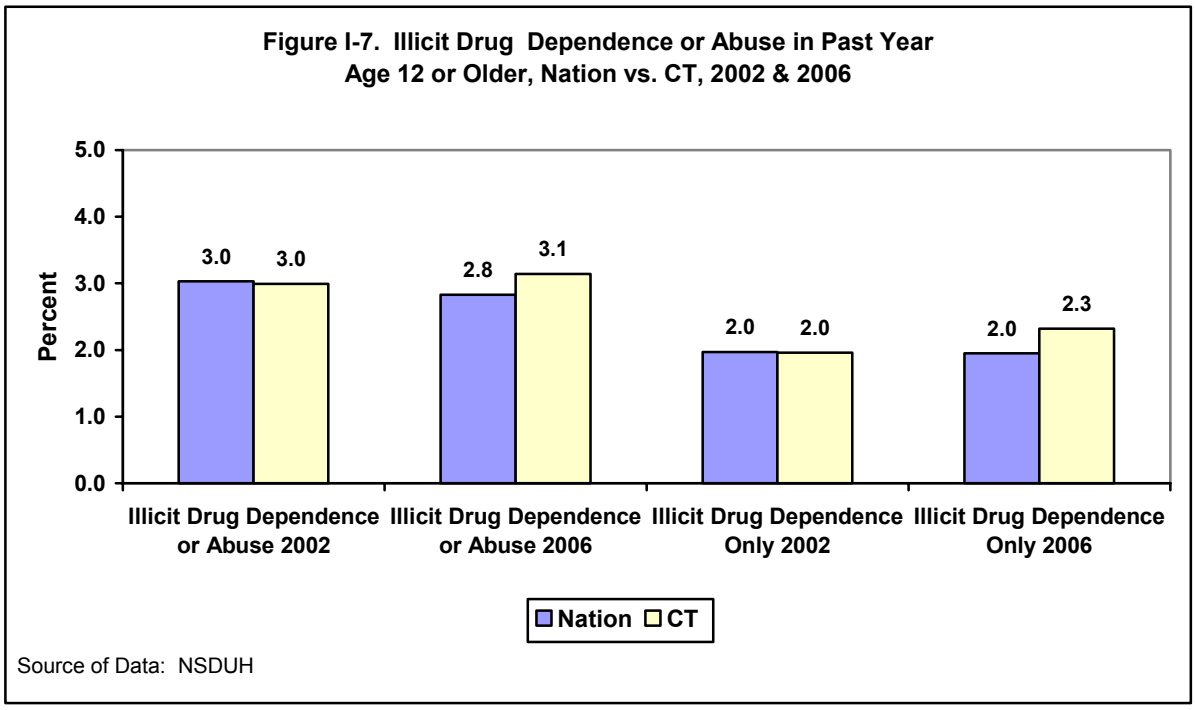


Source of Data: NSDUH

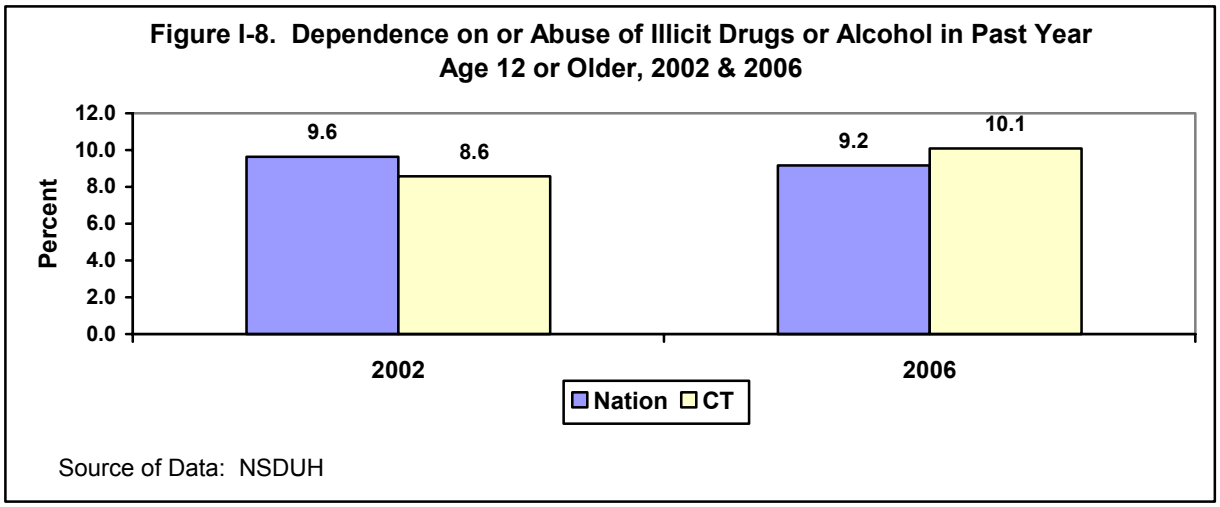
Alcohol dependence only. In 2006, 3.4 percent of persons age 12 or older nationally were estimated to be dependent on alcohol in the past year. This represents about 44 percent of those in the category of dependent on or had abused alcohol in 2006. In Connecticut, 3.3 percent of individuals aged 12 or older were dependent on alcohol in the past year, representing about 39 percent of those in the category of dependent on or abused alcohol. The highest rates for alcohol dependence were among the 18-25 year olds in Connecticut (8.5 percent) and the nation (7.4 percent). Compared to 2002, there has been little change in the rate of alcohol dependence.

Illicit drug dependence or abuse. With regard to Connecticut's rate of illicit drug dependence or abuse, there has been little change since 2002 within Connecticut or in comparison to the national rate. For 2006, as shown in Figure I-7, about 2.8 percent of persons age 12 or older nationally were dependent on or had abused illicit drugs in the past year, compared to about 3.0 percent in 2002. In Connecticut, the comparable figure for 2006 was 3.1 percent and for 2002 it was 3.0 percent.

Drug dependence only. Nationally, the percentage of persons in 2006 estimated to be dependent on illicit drugs in the past year was about 2.0 percent or about 66 percent of those who were estimated to be dependent on or had abused illicit drugs in the past year. In Connecticut, 2.3 percent were estimated to be dependent on illicit drugs in the past year, representing about 74 percent of those who were estimated to be dependent on or had abused illicit drugs in the past year. Similar to the rate of alcohol dependence, the highest rates for illicit drug dependence were among the 18-25 year olds in Connecticut (9.2 percent) and the nation (5.6 percent).



Alcohol or illicit drug dependence or abuse. Because a person could be abusing or dependent on both alcohol and illicit drugs, the NSDUH provides data on the overall rate. As with other measures, the rate in Connecticut is higher than in the nation as a whole. As shown in Figure I-8, the national rate in 2006 for past year dependence on or abuse of alcohol or illicit drugs among persons aged 12 or older was 9.2 percent, apparently a slight decrease from the 2002 rate. In Connecticut, the rate increased from nearly 8.6 percent in 2002 to 10.1 percent in 2006.



This means that the number of people in Connecticut age 12 and older estimated to have a current need for treatment for substance abuse or dependence based on the 2007 NSDUH survey is 295,000. As noted with the other dependence measures, 18 to 25 year olds had the highest rates of dependence on or abuse of alcohol or illicit drugs in Connecticut (29 percent) which was higher than the overall national rate (22 percent). Based on the 2007 NSDUH survey, the number of *adults* in Connecticut aged 18 and older estimated to have a current need for treatment for substance abuse or dependence is 268,000.

Demographic information. The 2003 Connecticut Adult Household Survey provides additional demographic detail about individuals with substance dependence or abuse, which is not available with NSDUH due to its smaller sample size.[10] It should be noted that there were differences between the two studies. The AHS targeted older persons (18 and older versus 12 and older), was administered differently (i.e., telephone survey for the AHS versus face-to-face), and was a larger sample.

Table I-3 shows certain demographic characteristics that are more likely to be associated with substance abuse or dependence than others based on criteria for lifetime substance dependence. Lifetime dependence means that an individual is currently dependent or has been dependent at some point in his or her lifetime.

Men were more likely to have higher rates of lifetime substance dependence than women, as were younger adults. Non-Hispanics had higher rates than Hispanics, while Blacks and Whites were more likely to report lifetime substance dependence that other racial groups. (While dependence for American Indians/Alaskan Natives appears high, the sample was too small to obtain an accurate assessment of this population.)

[10] The estimates provided are based on AHS Table 18. It includes estimated percentages of adults meeting past year DSM-IV criteria for substance abuse or dependence, which were adjusted from the Center for Substance Abuse Treatment (CSAT) initial protocol estimates. The federal funding agency required Connecticut to follow these protocols for its survey. CSAT had made some modifications to the NSDUH survey, which was the basis for the Connecticut survey. Some of the questions required by the CSAT protocol appear to have inflated the (unadjusted) estimates for abuse and dependence. A detailed explanation may be found in the full 2003 AHS document.

Table I-3. Estimated Percent of Adults Meeting Criteria for Lifetime Substance Dependence and Abuse by Demographic Characteristic: 2003			
Demographic Characteristic	***Percentage Meeting Criteria***	***Demographic Characteristic***	***Percentage Meeting Criteria***
Gender		**Ethnicity**	
Male	16.9	Hispanic	7.7
Female	5.9	Non-Hispanic	11.3
Race		**Age Group**	
Black	11.5	18-24	17.4
White	11.3	25-34	20.9
Asian	7.5	35-44	15.4
American Indian/Alaskan[11]	12.2	45-64	7.3
Other	6.8	65 and older	1.7
Educational Reference Group[12]		**Income**	
A-B	11.3	$0-$9,999	9.8
C-D-E	10.1	$10,000-$19,000	7.3
F-G	13.8	$20,000-$29,999	7.4
H	14.8	$30,000-$39,999	14.5
I	10.1	$40,000 or more	13.7
Education		**Current Employment**	
< High School	13.7	Full Time	13.8
High School	11.7	Part Time	11.4
Some College	11.3	Unemployed	23.6
College Grad. or more	9.3	Not in Labor Force	4.4
Source: Connecticut AHS			

Lifetime substance dependence was also associated with those with less than high school education as were the unemployed. However, higher incomes ($40,000 or more) were also more likely to meet the criteria for lifetime substance dependence. The second lowest and intermediate socio-economic levels, based on Educational Reference Groups, had the highest levels of lifetime substance abuse.

Connecticut Treatment Data

Federal and state information systems to collect data about substance abuse treatment, in terms of services provided, client characteristics, and treatment outcomes, were initiated in the 1990s. The two main federal sources of treatment data for Connecticut are:

[11] While dependence for American Indians/Alaskan Natives appears high, the sample was too small to obtain an accurate assessment of this population.

[12] Educational Reference Group (ERG) refers to the assignment of Connecticut's municipalities into one of nine groups that are determined according to socio-economic status and other factors. The most affluent towns begin in ERG A, the least affluent are represented in ERG I.

- the *Treatment Episode Data Set (TEDS),* which contains year-to-year, standardized information on publicly funded substance abuse treatment services and clients in every state; and
- the *National Survey of Substance Abuse Treatment Services (N-SSATS)*, which compiles annual information about all licensed, certified, and/or state-administered substance abuse treatment facilities in each state.

Both TEDS and N-SSATS are overseen by the Substance Abuse and Mental Health Services Administration. As noted earlier, SAMHSA also conducts the National Survey on Alcohol and Drug Use and Health each year. NSDUH provides some information on treatment needs on a state-by-state basis, as well as extensive prevalence data.

At the state level, the Department of Mental Health and Addiction Services has developed a comprehensive database on state alcohol and drug treatment called the *Substance Abuse Treatment Information System (SATIS)*. At present, client-level admission and discharge information is reported to SATIS by all private substance abuse programs licensed by the state Department of Public Health and by treatment programs operated by DMHAS and DOC.

In 1999, the General Assembly mandated comprehensive information on substance abuse prevention, intervention, and treatment be compiled, analyzed, and reported by DMHAS. Every two years, DMHAS, in collaboration with other state agencies, prepares a report based on SATIS data, and submits it to the legislature, OPM, and the State Alcohol and Drug Policy Council. By law, this biennial report must include a summary of:

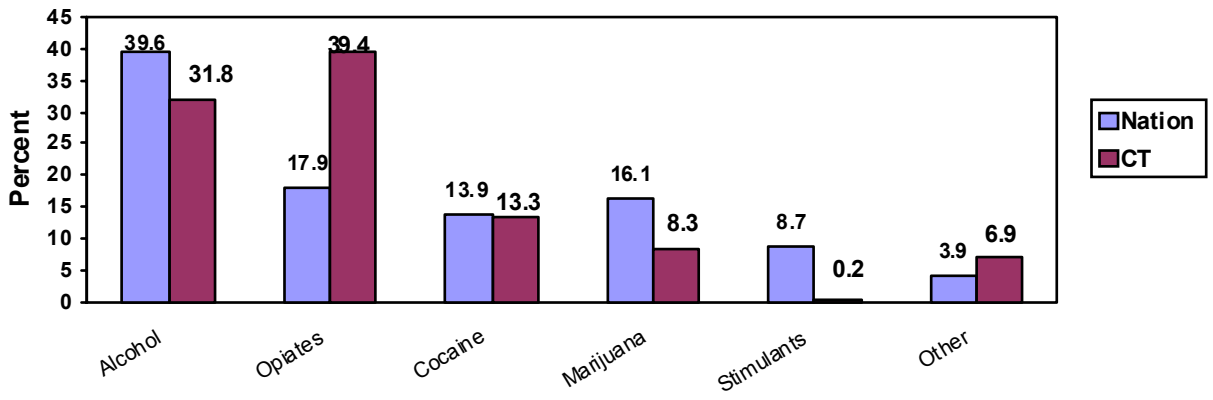
- client and patient demographic information;
- trends and risk factors associated with alcohol and drug use, abuse, and dependence;
- service effectiveness based on outcome measures; and
- a state-wide cost analysis.

The most current biennial report, which presents substance abuse treatment data as of state fiscal year 2005-06, was published in June 2007.

All three data systems are described in more detail in Appendix A. Taken together, data from these sources allow examination of trends in substance abuse treatment, as well as comparison of services and clients, at a state and national level.

Primary problem substance. Data on primary problem substance at time of admission for treatment in Connecticut is compared to national statistics in Figure I-9. A smaller portion of Connecticut admissions than for the nation as a whole reports alcohol as the primary substance problem (31.8 percent vs. 39.6 percent). Compared to national figures, the percentage of admissions in Connecticut reporting opiates (heroin, morphine, etc.) as the primary problem substance is very high (39.4 percent vs. 17.9 percent), while the percent of admissions reporting stimulants the primary problem is very low (0.2 percent vs. 8.7 percent).

Figure I-9. Percent of Admissions by Primary Substance of Abuse: Nation and CT 2006

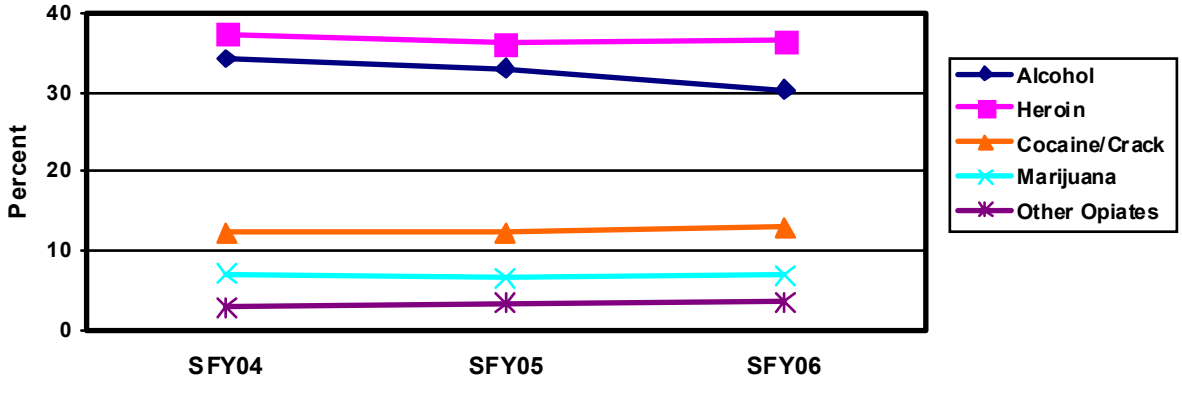


Source of Data: SAMHSA, TEDS Highlights Report on Admissions, 2006

Data on trends in primary substance abuse problem at the time of admission over a recent three-year period in Connecticut is summarized in Figure I-10.As DMHAS points out in the 2006 biennial substance use report, there has been a downward trend in the percentage of clients reporting alcohol as their primary problem substance over this time period. Admission for cocaine (powder and crack) increased slightly during the first two years shown but then leveled off in FY 06. There has been very little change in the portion of admissions for problem marijuana use.

Figure I-10 also shows the rate of primary heroin admissions to treatment continues to be significant, although in contrast to steady increases in prior years, this rate dropped and began to level off during FYs 05 and 06. However, the percentage of admissions related to other problem opiates, such as the prescription pain medications oxycodon and vicoden, shows a slow but steady rise.

Figure I-10. Primary Problem Substance at Time of Admission in Connecticut: State FYs 04 - 06

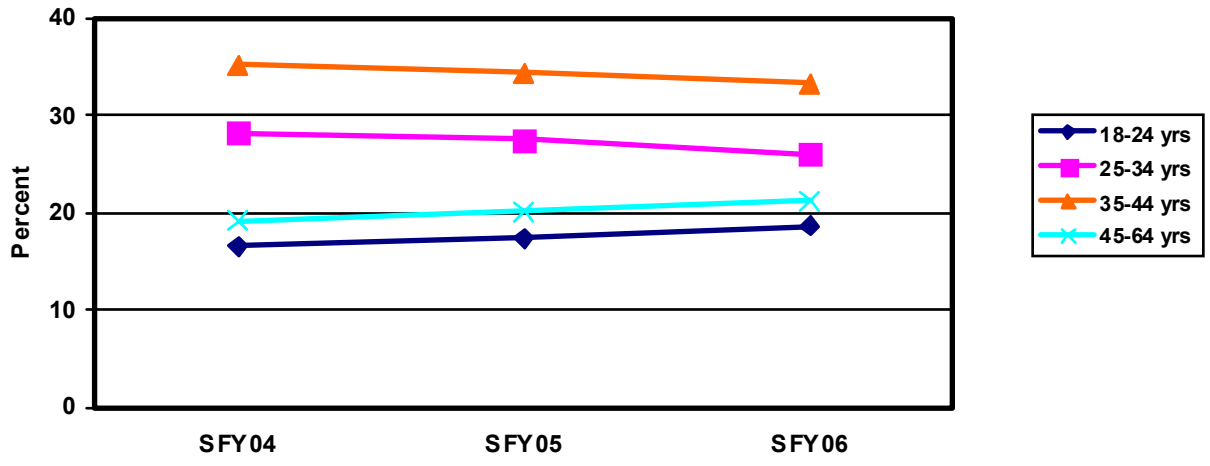


Source of Data: DMHAS 2006 Biennial Report, June 2007

In the 2006 biennial report, DMHAS also notes what it considers a disturbing increase in admissions for heroin treatment among young adults (those age 18-24). The department believes the growing non-medical use of synthetic opiate pain relievers, particularly among young persons, in Connecticut and across the country may be contributing to such trends in treatment admissions.

Client characteristics. Information on age at the time of admission for Connecticut adults is summarized in Figure I-11. The percent of treatment admissions by two groups, young adults (age 18 to 24) and those age 45 years and older, continued to increase over the three-year period shown in the figure; the percent of admissions for the other two groups (25-34 years and 35-44 years) dropped. (Admissions by those age 65 years and older account for 0.5 percent or less of annual totals and are not represented in the figure.)

Figure I-11. Admission to Treatment in Connecticut by Age: State FYs 04 - 06



Source of Date: DMHAS 2006 Biennial Report, June 2007

DMHAS notes further in the 2006 biennial report that the average age at admission has changed little over time, remaining fairly constant at 35.5 years. According to the department, this trend underscores the need to improve the availability of age-appropriate substance abuse services and to provide them to clients earlier.

Overall, clients served by the Connecticut substance abuse treatment system in FY 07 were about 58 percent White, 20 percent Black, and 24 percent Hispanic. DMHAS estimates men used about 70 percent of all treatment episodes it operated or funded that year.[13] Table I-4, which is based on the department's most recent SATIS data, summarizes key client characteristics of persons admitted to treatment in Connecticut by their primary problem substance.

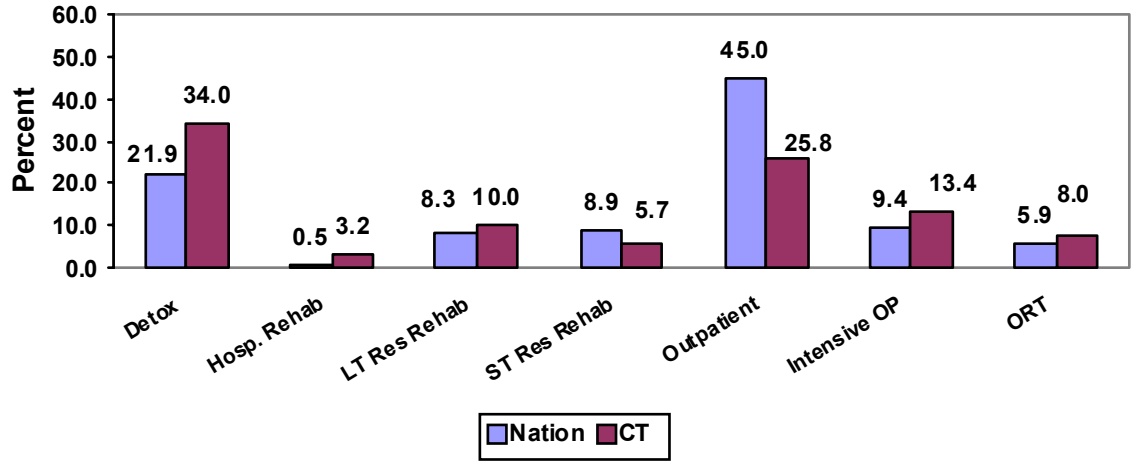
[13] From the DMHAS substance abuse block grant application FY 2008, see p. 19

Table I-4. Characteristics of Substance Abuse Treatment Clients in Connecticut, SFY 06				
	Alcohol	**Heroin**	**Cocaine**	**Marijuana**
% Female	25.9	26.3	36.8	21.4
Avg. Age (yrs)	39.7	34.3	36.2	26.9
Race				
% White	69.0	57.9	46.5	39.3
% Black	18.7	11.9	36.9	38.4
% Other	12.4	30.2	16.6	22.3
Ethnicity				
% Hispanic	19.9	39.1	24.0	33.5
% Non-Hispanic	80.1	60.9	76.0	66.5
Source of Data: DMHAS 2006 Biennial Report, June 2007				

Table I-4 shows client characteristics vary with the reported primary problem substance. Those admitted to treatment for alcohol use disorder are predominately white, male, and older. Admissions reporting marijuana as their primary problem generally are younger and male while those reporting problem cocaine use are disproportionately female and Black. As DMHAS discussed in the 2006 biennial report, the table also reflects the disproportionately higher admission rate for heroin treatment found among those who are Hispanic.

Type of treatment. At the national level, the best available information on the level of care received by individuals in need of substance abuse treatment comes from the federal TEDS discharge data. Information on the type of treatment at time of discharge for Connecticut clients in 2005 is summarized and compared to national figures in Figure I-12.

Figure I-12. Percent of Discharges by Type of Service: National and CT, 2005



Source of Data: SAMHSA, TEDS Highlights Report on Discharges 2005

In Connecticut, detoxification was the most frequently reported level of care at time of discharge (34 percent). Nationally, the largest portion of treatment discharges was from regular outpatient services (45 percent). Connecticut also had higher rates of use for hospital and long-term residential rehabilitation services, intensive outpatient services, and opiate replacement therapy (ORT) than the nation as a whole. Greater amounts of clients receiving detoxification and ORT services is likely related to the fact that a larger portion of those admitted for treatment in Connecticut report heroin as their primary problem substance.

As noted earlier, the level of treatment received depends on the person's problem substance, along with the severity of the alcohol and/or drug dependence, and other individual characteristics. Information on types of services received by those admitted for treatment in Connecticut during FY 06 is presented by primary problem substance in Table I-5.

Table I-5. Service Level of Substance Abuse Treatment Admissions in Connecticut, FY 06

	Alcohol	Heroin	Cocaine	Marijuana
% Residential Detoxification	31.1	37.3	5.4	0.0
% Residential Rehabilitation	19.4	17.2	32.6	11.5
% Outpatient Services	49.3	15.9	61.5	88.5
% Methadone Services	0.0	24.5	0.0	0.0
% Ambulatory Detoxification	0.2	5.1	0.5	0.0

Source of Data: DMHAS, 2006 Biennial Report, June 2007

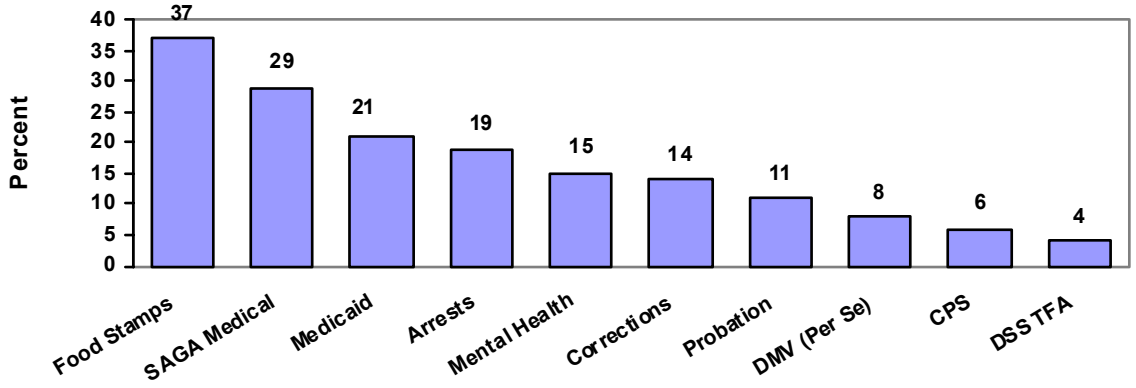
The table indicates those admitted with alcohol use disorders and heroin addiction mainly used residential detoxification services followed by ambulatory services (i.e., outpatient and methadone treatment). Persons with cocaine addiction were treated mostly in residential rehabilitation and outpatient settings and the vast majority of those admitted for problem marijuana use received outpatient services. (As expected, methadone services were only received by those reporting heroin as their primary problem substance.)

In the 2006 biennial report, DMHAS points out the use of costly acute care services like detoxification has been decreasing since FY 03. The department attributes this to greater emphasis on connecting clients to residential treatment and outpatient services. Better care coordination and more use of medication-assisted therapies for opiate-dependent persons has been found to reduce relapses and repeated need for detoxification.

Population overlap. As discussed earlier, needs assessments and other substance abuse research indicate many within the criminal justice, welfare, and child protection systems, as well as large numbers of mental health clients, also require treatment for alcohol and drug dependence. Analysis of this "population overlap" among the substance abuse and other service systems can help to improve access to and quality of treatment.

Substantial progress has been made in linking state agency information to share data on clients but it is still not possible to easily track individuals across service systems. At present, DMHAS uses a statistical technique called PPE (probabilistic population estimation) to measure the overlap of clients among state agencies. The most recent PPE information on what other state programs persons in treatment for substance abuse were involved with, which represents activity during state FY 05, is summarized in Figure I-13.

Figure I-13. Percent of Persons Receiving Substance Abuse Treatment and Otherwise Served by State Agencies SFY 05

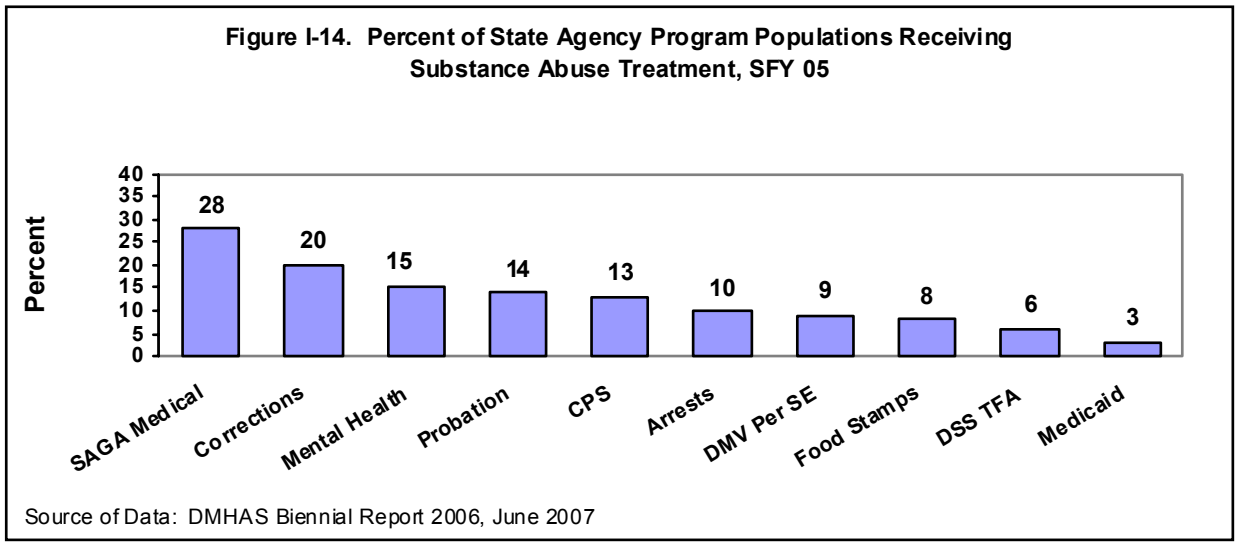


Source of Data: DMHAS Biennial Report 2006, June 2007

As Figure I-13 indicates, large proportions of those receiving substance abuse treatment are also served by programs administered by the Department of Social Services -- Food Stamps (37 percent), the State Assisted General Assistance (SAGA) Medical program (29 percent), Medicaid (21 percent), and to a much lesser extent, Temporary Family Assistance (TFA, 4 percent).

Overlap with the criminal justice system through arrests, probation, and corrections (incarceration and parole) is also significant (11 percent to 19 percent). About 15 percent of the substance abuse treatment population was also receiving DMHAS mental health services in SFY 05 and an estimated 6 percent were involved in the state child protective services (CPS) system. Another 8 percent of those receiving alcohol or drug treatment were participants in the Department of Motor Vehicles "Per Se" program for drivers subject to license suspension because of arrests for driving while intoxicated.

Figure I-14 shows the portion of clients receiving substance abuse treatment, or the treatment access rate, for various state agency populations during state fiscal year 2005. The SAGA medical program population, with 29 percent of all clients receiving alcohol or drug treatment, has the highest access rate; Medicaid and TFA client populations had the lowest rates (3 percent and 6 percent respectively).



Criminal justice population. DMHAS has given special attention to studying access to care for alcohol and drug dependence among the criminal justice population as research repeatedly demonstrates the many benefits of treatment for offenders include reduced recidivism. Two studies conducted by Yale University for the department have indicated 50 to 60 percent of those involved in the criminal justice system need substance abuse treatment. Comparing these treatment need rates to the treatment access rates presented earlier in Figure II-14 for those arrested (10 percent), on probation (14 percent) or in DOC custody (20 percent), clearly shows these populations are underserved.

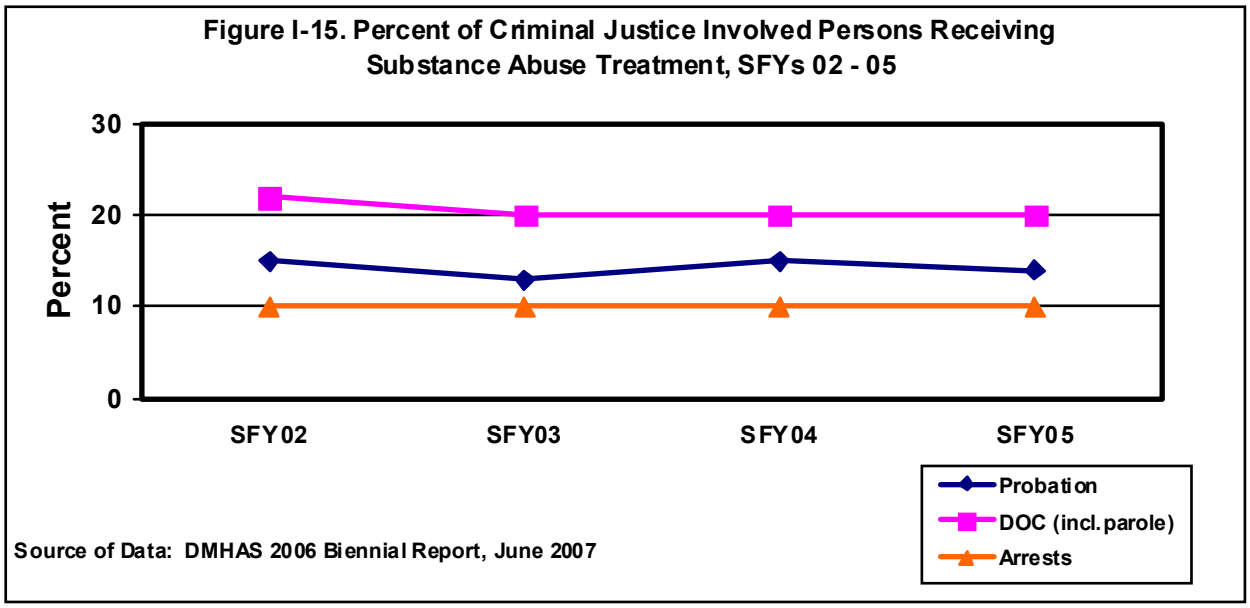
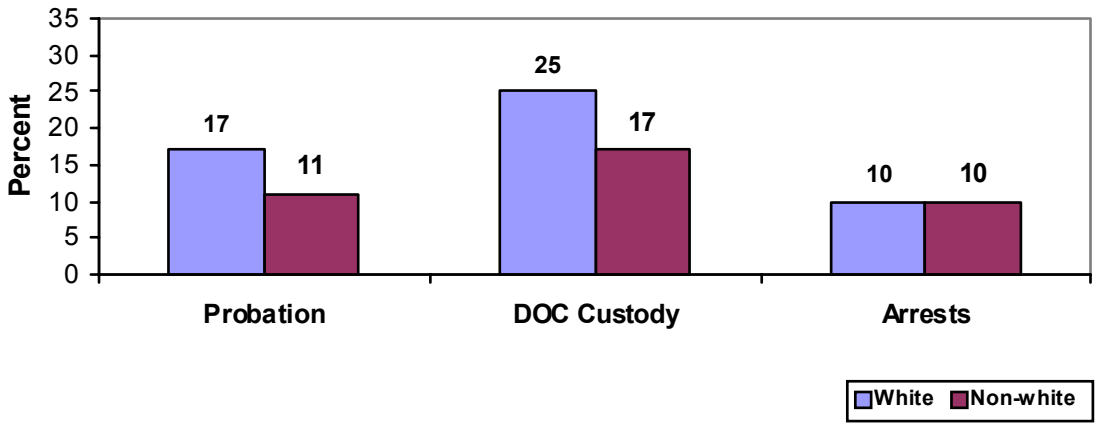


Figure I-15 illustrates trends in treatment admission rates for individuals arrested, serving probation, or admitted to or released from the correction department over a four-year period. Rates have remained about the same from FY 02 to FY 05 with the exception of the correction

population, which dropped from a high of 22 percent in the first year shown in the figure and then leveled off at 20 percent for the remaining years.

Additional analysis by DMHAS presented in the 2006 biennial report also shows access to substance abuse treatment by persons involved in the criminal justice system varies by race. As Figure I-16 indicates, in state fiscal year 2005, non-whites in the probation and DOC populations were less likely to receive treatment for alcohol and drug dependence. Among those arrested, there was no difference based on race.

Figure I-16. Criminal Justice Involved Persons Receiving Substance Abuse Treatment by Race, SFY 05

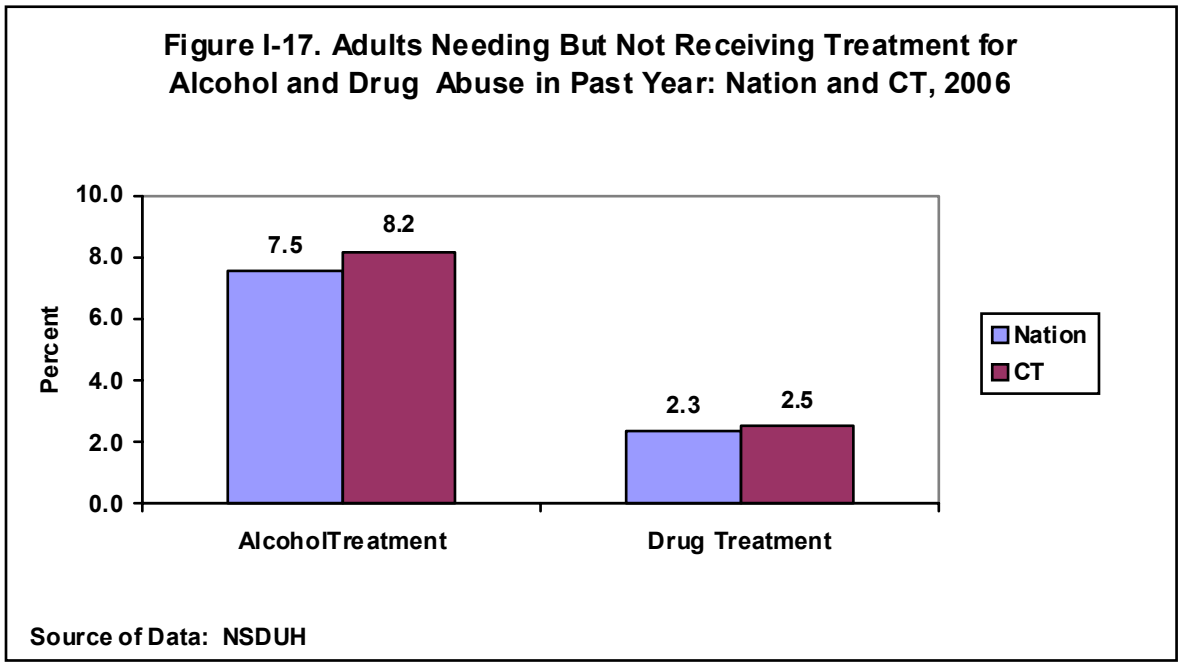


Source of Data: DMHAS Biennial Report 2006, June 2007

Treatment gap. Data comparing those in need of substance abuse treatment and those receiving it, or what is called the "treatment gap," is collected by the federal government each year through SAMHSA's National Survey on Drug Use and Health. Treatment gap estimates are developed for each state and the most recent information for Connecticut is presented in Figure I-17. Rates of unmet need are shown separately for alcohol and for drug dependency, and compared to rates for the U.S. as a whole. (As treatment gap data for adults are available for just two years at this time, trends are not discussed.)

The figure shows in 2006, 8.2 percent of persons age 18 and over in Connecticut needed but did not receive treatment for their alcohol use disorder and another 2.5 percent needed but did not receive treatment for an illicit drug use problem. These percentages represent approximately 204,000 and 66,000 Connecticut adults, respectively.

The treatment gap in Connecticut for alcohol and for drug abuse problems was slightly larger than national rates of unmet need. Based on 2002 data (the most recent available for all states), Connecticut was among states in the middle range regarding percentages of those needing but not receiving substance abuse treatment



Substance Abuse Treatment Overview

Substance abuse treatment includes a broad range of programs and services aimed at stopping harmful alcohol and drug use and returning individuals to productive functioning in their family, community, and work environments. Treatment is provided at varying levels of intensity and in many settings, from hospitals and other 24-hour care facilities to outpatient clinics and other community-based locations. This section provides an overview of the major types of treatment available for adults with alcohol and drug use problems.

Treatment defined. Substance abuse treatment encompasses an array of clinical therapies designed to address psychological, social, behavioral, and medical problems related to alcohol and drug dependency. It may involve behavioral therapies, pharmacological therapies (medications), or a combination of both approaches. Supplemental services that can support recovery and reduce relapse, such as help with employment, childcare, housing, education, transportation, and life management, are also an important component of substance abuse treatment.

In addition to many types of therapies and services for substance abuse, there is a broad range in treatment intensity. Intensity refers to treatment elements such as frequency and duration of therapy sessions, and the level of clinical and other supervision provided during care. Best practices require that treatment strategies be customized to take into account the nature and severity of the substance abuse problem as well as an individual client's personal characteristics and needs. The primary treatment approaches for adults with substance abuse problems are described briefly below.

Behavioral therapies. Professional counseling and other behavioral ("talk") therapies are designed to help people modify their attitudes and behaviors related to drug and alcohol

abuse and increase their life skills so they can stop using and sustain recovery. Behavioral therapies also can help individuals engage in the treatment process, stay in treatment longer, and make medication therapies more effective. Family therapy and couples therapy are often used in combination with individual counseling sessions during substance abuse treatment.

Among the successful behavioral approaches to substance abuse treatment are:

- *Motivational interviewing*: incorporates techniques that help individuals recognize the harm caused by their substance abuse and encourage them to take positive action toward recovery;
- *Cognitive therapy:* teaches individuals about the reasons for their addiction and skills for coping with cravings and relapse triggers; and
- *Positive incentives*: provides small motivational bonuses (gift certificates, affirmations, additional privileges) when patients make treatment progress to help encourage and reward positive accomplishments.

Pharmacological therapies. In some cases, prescription medications are used to help people stop abusing alcohol or certain other drugs, stay in treatment, and avoid relapse. In addition to changing the brain activity involved in addiction, medications can help patients with stress, which may trigger relapses, treat co-occurring conditions (e.g., depression), and be used to suppress withdrawal symptoms during detoxification. At present, approved medications are available for treating alcohol and opioid dependence (see Table I-6). Promising research is underway to develop new pharmacological therapies, particularly for treatment of cocaine, marijuana, and methamphetamine abuse.

Table I-6. Medications Used for Substance Abuse Treatment.

	Medication (Brand Name)	**Date FDA Approved**
Alcohol	Disulfiram (Antabuse)	1949
	Naltrexone (ReVia)	1994
	Acamprosate (Campral)	2004
Opiates (Heroin, prescription painkillers, e.g., OxyCotin, Percocet, Percodan)	Methadone	1973
	Buprenorphine (Suboxene, Subutex)	2002
	Naltrexone (ReVia)	1985

Source of Data: John Hoffman and Susan Froemke, eds., *Addiction: Why Can't They Just Stop* (New York: Rodale, 2007)

Pharmacological treatment for heroin and other opiate addictions, while shown to be very effective, has a somewhat negative public image. Under the treatment approach known as opiate replacement therapy (ORT), addicted individuals receive a medication that blocks the "high" induced by opiates and eliminates cravings. However, patients remain dependent upon the replacement medication and must continue in maintenance programs, often for many months or even years. Some question the validity of long-term maintenance but addiction experts point out,

when provided in conjunction with effective behavioral therapies, ORT is the most successful treatment approach for adults with an opiate dependency that has lasted more than a year.

Until very recently, replacement therapy with methadone was the primary treatment for opiate addictions. Methadone is a synthetic narcotic originally developed as a pain medication during World War II. Due to its high potential for misuse, it is one of the most strictly regulated drugs in the U.S. and requires careful medical supervision. Under federal law, as a treatment for opiate addiction, methadone can only be administered through a licensed clinic and for the most part, patients must receive daily doses of the medication at the clinic site.[14] At this time, methadone is the most widely used and cost-effective treatment for opiate addiction in the United States. According to DMHAS, on average, it costs about $90 per week to treat an adult in a Connecticut methadone maintenance program.

A new medication for treating opioid addiction, buprenorphine, has several advantages over methadone. It can be taken in pill form, be prescribed by a physician, and distributed through a regular pharmacy, making its treatment more flexible and convenient for clients than daily visits to a methadone clinic. It also is less likely to cause an overdose and causes less physical dependence. The main drawback to buprenorphine is its price. The weekly rate paid for buprenorphine treatment under a DMHAS program called Access to Recovery is $157.

Self-help support groups. Mutual assistance groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Smart Recovery are an important resource for many people with substance abuse problems. Participation in such groups is not considered treatment for alcohol or drug dependence by most experts in the field but its valuable contribution to successful recovery is widely recognized. National studies show more people receive help for alcohol and drug problems through mutual assistance groups than through any type of formal treatment.

Self-help organizations like AA and NA provide members with a support network as well as a personal recovery process, often referred to as a 12-step program. The primary group activity is attending meetings, led by volunteers, where members are expected to discuss all aspects of dealing with recovery with honesty, respect, and confidentiality. Most groups have a spiritual component but not any religious element. In general, none employ therapists or other professional treatment staff and there are no fees or charges.

Treatment settings. The continuum of care for substance abuse includes very intensive hospital services, e.g., medically managed, 24-hour inpatient acute care and evaluation, and a series of residential treatment levels with decreasing amounts of clinical treatment and medical monitoring.[15] For those who are able to live independently while receiving treatment, ambulatory or outpatient services also ranging in intensity are available. Ideally, completion of primary treatment is followed by a period of continuing care, generally on a less frequent basis, and supplemental, community-based services that support recovery.

[14] Methadone clinics must meet extensive SAMSHA licensing standards and be DEA certified.

[15] In general, medically managed care means medical staff are present on a 24-hour basis while medically monitored care refers to the availability of medical staff, via phone or back-up service, on a 24-hour basis.

Residential. Settings for residential care include general hospitals and 24-hour care facilities specializing in substance abuse treatment, as well as halfway houses and other supervised living arrangements that provide clinically managed services to residents. One of the most intensive types of residential treatment is what is called "therapeutic community," a highly structured residential program with a planned length of stay of 6 to 12 months. Therapeutic communities are focused on helping individuals learn socially acceptable behaviors and develop personal accountability and responsibility with the support of the whole program community (staff and peers).

Ambulatory. In addition to regular and intensive outpatient treatment programs, ambulatory services include partial hospitalization and day (or evening) treatment programs. The latter programs incorporate more frequent and higher levels of care and medical supervision, usually serving as a transition phase for those leaving a residential placement. Both regular and intensive outpatient treatment involve evaluation, treatment, and recovery support services provided by addiction personnel and clinicians in the community; the main difference is frequency of therapy (i.e., in general, regular is less, and intensive is more, than nine hours per week).

Treatment categories. While there are numerous therapies and many settings for treating alcohol and drug abuse, there are three main stages of treatment: detoxification and stabilization; rehabilitation; and aftercare, also called continuing care. Each stage is described briefly below and summarized in Table I-7.

Detoxification and stabilization. Detoxification is the process of helping a person dependent on one or more substances safely and comfortably withdraw from dependence and become free of toxins. Alcohol and other drugs with serious withdrawal symptoms (opiates and tranquilizers) usually require medically supervised detoxification services. In some cases, untreated withdrawal can be medically dangerous or even fatal.

Because detoxification addresses the acute physiological effects of stopping alcohol or drug use, it is considered a precursor to treatment; it is only the first step of what should be a comprehensive treatment strategy. Detoxification has levels of intensity and matching the patient to the appropriate setting is an important clinical decision. For some patients, the process can be carried out in a doctor's office. Others in an outpatient setting may need intensive monitoring by nursing staff, sometimes referred to as "social setting" detoxification. The most intensive (and expensive) level is provided in an acute care hospital with full medical management.

Medically supervised detoxification can involve pharmacotherapy, or treatment with drugs that minimize withdrawal symptoms. Other therapies available during detoxification may include individual assessment, brief interventions and family involvement, and discharge or transfer planning.

Stabilization refers to early treatment aimed at addressing the acute physical, psychological, or emotional emergencies related to excessive alcohol or drug use. The two key components are assessment and brief intervention. Both can help begin the recovery process by

determining an individual's treatment needs and engaging the person in continued rehabilitative care.

Table I-7. Main Categories of Substance Abuse Treatment

	Detoxification/ Stabilization	Rehabilitation (Active Treatment)	Aftercare
Settings	• Inpatient hospital • Residential facility • Outpatient	• Residential (free-standing specialty facility or hospital-based program) • Outpatient	• Community-based
Components	• Assessment • Medication to reduce severity of withdrawal • Medical care and monitoring as needed • Sometimes brief treatment, acute clinical intervention	• Array of therapies and treatment programs to address health and social problems associated with substance abuse • Often includes supplementary services	• Monitoring and support services to maintain long term recovery
Duration	• Generally 3-5 days	• Residential generally ranges short-term (under 30 days), intermediate, or long term (90 days or more) • Outpatient services vary in intensity (e.g., from 2-8 hours per day, 2-5 days per week, over a period of several weeks or months)	• Generally 6-12 months following completion of rehabilitation
Goal	• Remove drugs from patient's system; address acute physical, social, or psychological emergency caused by excessive alcohol or drug use; begin recovery process by engaging patient	• Sustain elimination of alcohol and other drug use; improve health and social functioning; engage patient in continuing care	• Help recovering individual: self-manage cravings/ temptations; sustain elimination of alcohol and other drug use; maintain healthy lifestyle and develop fulfilling life

Source: Adapted from *Addiction: Why Can't They Just Stop, Chapter Four:Treatment*, John Hoffman and Susan Froemke, eds., (New York: Rodale, 2007).

Rehabilitation. Rehabilitation is the appropriate stage of treatment when an individual's substance abuse problem is stabilized and any related acute conditions (physical or emotional) have been addressed. Typically, rehabilitation is a formal program of an array of treatments that can include: medication to reduce cravings; various behavior therapies; substance abuse education; and various supplementary services. It can be provided in both residential and ambulatory settings.

In general, the most severe alcohol and drug abuse cases require residential rehabilitation treatment. Individuals whose lives are out of control or who lack strong supports in the community generally need 24-hour care and supervision. Some patients transition from residential settings through a series of less intensive care levels -- partial hospitalization, day treatment, intensive outpatient, and regular outpatient -- while others move directly from

residential to regular outpatient services. Those starting with less severe substance abuse problems, and who have supportive families and stable employment, usually can begin their rehabilitation process on an outpatient basis.

Aftercare/continued care. Once rehabilitation or primary treatment process is completed, an individual may continue to receive similar therapeutic services (e.g., individual/group/family therapy, relapse prevention education, and guidance on daily living skills) but usually on a less frequent basis. The best aftercare programs include supports to prevent relapse and maintain recovery such as assistance with housing, employment, or transportation. Mutual assistance groups like AA and NA often have an important role in aftercare.

Continuing care is intended to help recovering individuals adjust to their lives in a community setting by monitoring their status and providing needed supports. Research shows individuals are most vulnerable to relapse during the first three to six months following active treatment so providing effective aftercare in this period can contribute to successful recovery.

Treatment effectiveness. With substance abuse now recognized as a chronic, recurring disease, it is also understood that repeated episodes of treatment may be required before the ultimate goal of sustained abstinence is reached. Avoiding relapse, which is often part of a person's recovery process, cannot be the sole measure of treatment effectiveness. As with other continuing care conditions, reasonable expectations for substance abuse treatment include what can be considered intermediate goals: reduced use; improved functioning; minimized medical complications; and fewer negative social consequences (e.g., criminal activity) related to alcohol and drug abuse.

A substantial body of scientific research, much of it federally funded, exists concerning the effectiveness of substance abuse treatment in terms of these goals. Longitudinal studies of various programs and clinical practices began in the 1970s and continue today, producing extensive evidence on successful approaches for treating drug and alcohol dependence. This research is the basis for much of the evidence-based practice found in high quality treatment programs.[16] Key findings from several national evaluations of substance abuse treatment conducted over the past three decades are highlighted below.

National evaluation results. To date, three major longitudinal studies of publicly funded substance abuse treatment have been carried out by the National Institute on Drug Abuse (NIDA). Each one has:

- evaluated treatment outcomes;
- analyzed treatment issues (e.g., service delivery, access, and client engagement and retention); and

[16] According to SAMHSA, evidence-based practices generally refer to approaches to treatment that are validated by some form of documented scientific evidence. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practices stand in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

- identified emerging trends in client populations, substance use, funding, and treatment approaches.

The first study, the ***Drug Abuse Reporting Program (DARP)***, collected initial data between 1969 and 1972 on 44,000 clients served by 139 separate programs across the country and included a series of follow-up studies on outcomes up to 12 years after treatment. During this time, the country was experiencing a growing heroin epidemic and many of the clients in the DARP study were using opiates on a daily basis. Among the study's most significant findings:

- *Time spent in treatment was a major predictor of post treatment outcomes*; stays of 90 days or longer were significantly associated with favorable outcomes.
- Community-based treatment for opiate addiction was found to be effective in terms of *reduced drug use and reduced criminal behavior*.
- The six-year follow up of opioid addicts showed the majority (61 percent of these clients) had quit daily opiate use for a full year or longer and had improvements in employment, use of other substances (alcohol or other nonopioid drugs), and criminal activity; *on-going treatment or returning for subsequent treatment was associated with better outcomes*.

NIDA expanded its research scope in its second national evaluation, the ***Treatment Outcomes Prospective Study (TOPS)***, to include specialized studies of co-occurring conditions, cost-effectiveness, and the impact of criminal justice involvement in addition to general treatment program effectiveness. The TOPS study, which gathered data on 11,750 clients admitted to 41 different treatment programs in 10 U.S. cities between 1979 and 1981, produced the following major findings:

- *Treatment was effective in reducing daily opiate use and other illicit drug use* during and after the treatment period (a finding supporting the earlier DARP study results).
- Clients with *pressure from the criminal justice system to enter treatment were just as likely as those entering treatment voluntarily to benefit* from substance abuse treatment.
- Study results concerning methadone maintenance programs showed client retention rates, a factor critical to *treatment success, were higher for programs with flexible dosing policies, specialized personnel, frequent urine monitoring, and comprehensive services.*

The third national evaluation of the effectiveness of public substance abuse treatment services, the ***Drug Abuse Treatment Outcomes Studies (DATOS),*** was initiated in 1990. Baseline data for the DATOS studies were collected for more than 10,000 adults entering 96 separate treatment programs located in 11 representative cities during 1991-1993. Follow-up data were gathered at several different points (from three months to five years after treatment) for certain samples of clients. Four research centers to conduct on-going, coordinated research in

several key areas of study (e.g., service delivery and access, client engagement and retention, treatment for substance-abusing offenders, and trends in treatment effectiveness) were also created as part of DATOS.

To date, numerous reports on all aspects of treatment effectiveness have been, and continue to be, produced based on analysis of the DATOS data files. In the late 1990s, NIDA reviewed all results from the many studies based on DATOS research, as well as from the earlier national studies, to identify principles that should form the basis of any effective treatment program. The principles, described below, were published as a "research-based guide" in 1999. Overall, they underscore the complex nature of substance abuse and the need for a continuing care strategy for treatment of alcohol and drug dependency, like other chronic diseases.

NIDA Principles. The 13 principles discussed in the NIDA guide for addiction treatment are summarized in Table I-8. As the table indicates, what is central to effective treatment is a continuum of customized care that addresses all aspects of an individual's life (medical, emotional, psychological, behavioral, and social) and includes "follow up options" for supporting recovery (e.g., community- or family-based service systems).

Table I-8. NIDA Principles of Effective Treatment

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves and others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Source: National Institute on Drug Abuse, National Institutes of Health Publication No. 00-4180, *Principles of Drug Addiction Treatment: A Research-Based Guide*, 1999.

According to these principles, other critical components of effective treatment are: ready availability of treatment; continuous monitoring of possible substance use during treatment; and

adequate time in treatment. Contrary to some popular opinion, research shows treatment does not have to be voluntary to be effective. Finally, successful outcomes may require more than one treatment episode, and research shows, in many cases, multiple episodes of treatment have a cumulative impact.

NIDA published another research-based guide targeted to substance abuse treatment for those in the criminal justice system in July 2006.[17] It contains many of the same principles as the 1999 guide but highlights the research finding that addiction is a brain disease and emphasizes that a comprehensive assessment is the first step in the treatment process.

In addition, several principles in the criminal justice treatment guide focus on factors specific to treatment for drug-abusing criminal offenders. They include the following guidelines: correctional supervision must balance rewards and sanctions to enhance treatment participation and prosocial behavior; continuity of care is essential for maintaining recovery of drug abusers treated in prison when they re-enter the community; and criminal justice supervision should incorporate treatment planning for drug abusing offenders to improve the success of community re-entry and substance abuse treatment provided during parole and probation periods.

In many ways, findings presented in the NIDA research-based guides can be viewed as best practices for treatment programs. For example, the research clearly demonstrates good outcomes are contingent upon adequate lengths of treatment. According to the guides, residential or outpatient treatment participation for less than 90 days is of limited or no effectiveness; for methadone maintenance, 12 months of treatment should be considered the minimum, and for some individuals addicted to opiates, several years of treatment is beneficial.

Regarding treatment program operations, NIDA found the following practices contribute to better outcomes:

- ensuring counselors are able to establish positive, therapeutic relationships with clients;
- establishing and following an individualized treatment plan;
- making an array of services (medical, psychiatric, social services) available to clients; and
- providing transition to continuing care (aftercare) after completion of formal treatment.

NTIES results. The ***National Treatment Improvement Evaluation Study (NTIES)***, considered one of the largest and most rigorous substance abuse research projects carried out in the United States, was a five-year study mandated by Congress in 1992. NTIES examined service delivery issues (e.g., organization, budget, staffing, and use of federal funds) for all programs in the country that received federal substance abuse treatment grants. It also evaluated, and continues to update, clinical outcomes for a representative sample of more than 4,400 clients

[17] National Institute on Drug Abuse, National Institutes of Health Publication No. 06-5316, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide*, July 2006.

served by these programs. The final report on the five-year study, issued in 1997, contained the following key findings:

- Clients served by the federally funded *treatment programs significantly reduced their alcohol and other drug use.*
- *Treatment had lasting benefits*, with significant reductions in drug and alcohol use reported a full year after treatment.
- One year after treatment, clients also reported *increases in employment and income; improvements in mental and physical health; and decreases in criminal activity, homelessness, and behaviors that put them at risk for infectious disease.*

Like earlier national studies, the NTIES evaluation study showed the positive outcomes of treatment (reduced drug and alcohol use as well as decreased criminal activity and increased employment) were better among those clients who: completed their treatment plans; received more intensive treatment, and were treated longer. The final report noted it was not clear how these treatment factors and other patient characteristics (e.g., demographics, legal status, and severity of problem) contribute to variation in clinical outcomes and suggested continuing research in this area.

Cost-effectiveness results. A number of the studies summarized above examined whether substance abuse treatment is cost-effective. NIDA, based on its examination of national research results, estimated in 1999 that every $1 invested in addiction treatment returned $4 to $7 in reduced crime and criminal justice system costs. Including projected cost-savings related to health care boosted the benefit ratio to $12 returned for every $1 invested.

The NTIES study found substance abuse treatment appeared to be cost-effective, particularly when compared to one alternative common for many individuals, incarceration. Cost estimates developed by the study researchers in the mid 1990s for various types of treatment were compared to the American Correctional Association's estimate of the annual cost of incarceration at the time. As Table I-9 shows, the cost to imprison a person for one year was significantly higher than the costs of any of the typical types of treatment for alcohol and drug dependency.

A more recent federally funded benefit-cost analysis of substance abuse treatment in California found similar results.[18] Published in 2006, this study concluded each dollar spent on treatment produced a $7 return on the investment. On average, substance abuse treatment in that state cost $1,583 and resulted in monetary benefits valued at $11,487. These benefits were primarily due to increased employment earnings and reduced costs of crime. (Direct benefits to clients such as improved health and quality of life were not addressed in the analysis.)

[18] Ettner, et. al, *Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself?*", Health Services Research v. 41(1), pp. 192-213, Feb. 2006.

Table I-9. Comparative Costs of Treatment: 1997 NTIES Study Estimates		
Methadone maintenance	$13/day	$3,900/client (about 300 days)
Outpatient	$15/day	$1,800/client (about 120 days)
Short-term residential care	$130/day	$4,000/client (about 30 days)
Long-term residential care	$49/day	$6,800/client (about 140 days)
Substance abuse treatment in a correctional facility	$24/day*	$1,800/client (about 75 days)
One year of incarceration **	-	$18,330

*Cost over and above incarceration costs
** Estimate provided to NTIES researchers by American Correctional Association (based on 1994 data)

Source of Data: *NTIES Highlights* accessed Aug. 22, 2008 at www.ncjrs.gov/nties97/index.htm

Chapter II

Connecticut Substance Abuse Treatment System

Substance abuse treatment in Connecticut is defined by state law as a continuum of inpatient and outpatient services and care that includes "… diagnostic evaluation, medical, psychiatric, psychological and social services, vocational and social rehabilitation, and other appropriate services which may be extended to alcohol-dependent, drug-dependent, and intoxicated persons." (See C.G.S. §17a-680(16).) The Department of Mental Health and Addiction Services, as the state's lead substance abuse agency, has primary responsibility for planning and coordinating the state's system of alcohol and drug abuse treatment services.

DMHAS also is a major provider of publicly funded treatment services; it operates three state inpatient facilities and funds a statewide network of more than 150 private providers of all levels of substance abuse treatment through grants and fees-for-service. However, other state agencies and the Judicial Branch fund, and in the case of the Department of Correction, even operate, substance abuse treatment services for the adult clients they serve.[19]

DMHAS and the other state entities that provide or fund substance abuse treatment serve two main populations of adults: persons with substance use disorders who lack the financial means to obtain care on their own; and individuals involved in the criminal justice system who have alcohol and drug dependency problems. For the most part, adults with private health insurance, or the ability to pay for care on their own, obtain services they need for alcohol or drug dependency outside of DMHAS and other state-operated facilities and programs. Many of the private providers contracted to care for state agency substance abuse treatment clients, however, also serve private-pay patients.

An overview of the network of facilities and programs that constitute Connecticut's publicly supported treatment system for adults with substance use disorders is presented below. In addition, this chapter describes the role and responsibilities of the Department of Mental Health and Addictions Services as the state's lead agency for prevention and treatment of alcohol and other substance abuse, including: its current mission; organization; planning and coordination functions; resources for adult substance abuse treatment; and intake and assessement process.

The department's major treatment programs and services and key steps in the agency's treatment process for adults with substance use disorder also are summarized. The substance abuse treatment activities carried out for adults involved in the criminal justice system by the Court Support Services Division of the Judicial Branch and DOC are described separately in Chapters III and IV of this report.

[19] The Department of Children and Families, from the time it was established as the state's consolidated children's agency, has been responsible for providing and funding behavioral health services (including substance abuse prevention and treatment) for children and adolescents (anyone under age 18). DMHAS works with DCF, as well as a number of other state agencies and the Judicial Branch, to plan and coordinate all state alcohol and drug abuse services. In recent years, the agencies have been collaborating to improve transition services (for youth moving to the adult system).

State Treatment Programs and Providers

At present, the publicly supported substance treatment system for adults in Connecticut is composed of:

- state-operated substance abuse treatment programs at DMHAS facilities;
- alcohol and drug treatment programs operated by DOC within state correctional facilities;
- detoxification, residential rehabilitation, and other treatment services provided at general hospitals and at specialized private residential facilities; and
- a wide array of outpatient programs operated by licensed, private provider agencies, primarily nonprofit agencies, and treatment services delivered in the community by private practice physicians and other licensed professionals. [20]

In Connecticut, all privately operated behavioral health treatment services must be licensed by the state Department of Public Health (DPH). (Treatment programs and facilities operated by state or other government agencies are not subject to DPH licensing requirements.) As of November 2007, there were 181 private programs licensed by the state health department to provide alcohol and drug dependency services in Connecticut.

The majority of Connecticut's private substance abuse treatment programs (128) provide only outpatient services. Just under 30 percent (53) are licensed to provide various types of residential care for substance abuse. Most of these outpatient and residential programs are operated by private nonprofit provider (PNP) agencies. Many serve as substance abuse treatment contractors for state agencies and the Judicial Branch.

Program profile. The most comprehensive information on substance abuse treatment services in Connecticut is collected through SAMHSA's annual survey of all alcohol and drug facilities in the country (N-SSATS). The most recent national survey data about Connecticut facilities, summarized in Table II-1 below, are for 2006. [21]

As Table II-1 indicates, the vast majority (86 percent) of the substance abuse treatment facilities in Connecticut are private non-profit organizations. They also serve 86 percent of the more than 22,000 adult clients in treatment at the time of the survey. Government-operated facilities accounted for just under 10 percent of the total number of alcohol and drug treatment providers and a similar proportion of clients. (The client figures include all adults in treatment

[20] The government-operated alcohol and drug treatment programs at state and federal veterans' hospitals in Connecticut, because they are targeted to a special adult population and are relatively small scale, were not included in the scope of this study.

[21] The national survey attempts to identify all facilities -- public and private, for-profit and not-for-profit -- that offer alcohol and drug abuse treatment services in each state. For the most part, what N-SSATS counts as a facility is comparable to what DPH and DMHAS count as programs. However, there are some inconsistencies in the ways the federal and state agencies count separate programs located within the same facility (e.g., a residential treatment provider with one program for men and one for women at a single location) so total numbers of programs can vary depending on the data sources.

on the day of the survey, both public- and private-pay.) Only 12 of the 209 facilities operating in the state on March 31, 2006, were private for-profit entities.

Table II-1. Substance Abuse Treatment Facilities in Connecticut, March 2006

	No. Facilities	Pct. of Total	No. Adult Clients in Treatment	Pct. of Total
Private Not-For-Profit	179	86%	19,030	86%
Private For-Profit	12	6%	1,121	5%
State Government	12	6%	1,170	5%
Other Government	6	3%	843	4%
Total	209		22,164	

Source of Data: N-SSATS Connecticut Profile 2006

The majority of Connecticut facilities (63 percent) included in N-SSATS data were providers that specialize in substance abuse treatment. A little more than one-quarter (28 percent) were combination (mental health and substance abuse) treatment facilities. The primary focus of the remainder was only mental health (7 percent), or other (2 percent).

Information on the types of care provided by the state's substance abuse facilities and the number of clients receiving each level is summarized in Table II-2. A single facility can offer more than one type of care (e.g., regular and intensive outpatient, outpatient, and inpatient) About three-quarters of Connecticut facilities provide one or more types of outpatient services while nearly one-third have some type of residential care. Just 17 facilities were providers of hospital inpatient services.

Table II-2. Treatment Types and Clients Treated in Connecticut, March 2006

Type of Care	No. Facilities	No. Clients in Treatment*	Median No. Clients Per Facility
All Facilities	209	22,809	-
Outpatient	152	20,896	65
Regular	128	8,993	36
Intensive	79	1,468	12
Day Treatment/Partial Hosp.	39	474	7
Detoxification	32	352	6
Methadone	38	9,609	221
Residential	66	1,607	18
Short-term	21	338	16
Long-term	51	1,147	14
Detoxification	10	122	12
Hospital Inpatient	17	306	13
Detoxification	13	157	8
Rehabilitation	17	149	5

* Total number of clients in treatment on March 31, 2006 including clients under age 18 (645)

Source of Data: N-SSATS Connecticut Profile 2006

About 92 percent of the clients in treatment at the time of the survey were receiving outpatient care. Just 7 percent were in residential treatment facilities and only 1 percent were getting hospital inpatient care for their substance abuse problem. Slightly more than 40 percent of all those in treatment were receiving outpatient methadone services, which is about the same portion as those in regular outpatient care.

In general, the numbers of clients in treatment per facility in Connecticut are not large. The median number of clients treated in an outpatient facility, except for those providing methadone services, was 36 or fewer. For residential treatment facilities and inpatient hospitals the median number of clients in treatment was 18 and 13, respectively.

FUNDING for Substance Abuse Treatment

In Connecticut and nationally, substance abuse treatment, unlike other types of health care, is primarily government-funded. DMHAS estimates approximately 75 percent of the clients included in its substance abuse treatment reporting system (SATIS), which receives admission data from all licensed and all state-operated programs, are publicly supported. This means their service is paid for by a government program like Medicaid, or they have no insurance or ability to pay for substance abuse treatment.[22] Nationally, it is estimated at least 80 percent of addiction specialty care is paid for by federal, state, or local government.[23]

Under state law, most individual and group health insurance policies must provide benefits for diagnosis and treatment of substance use disorders on the same basis as any other medical condition. For example, lifetime and annual limits, deductibles, co-payments, and limits on inpatient and outpatient visits for treatment related to alcohol or drug dependency (and other mental illnesses) must equal those for physical illnesses. While a number of states have enacted mental health insurance parity laws in the past decade, only about a half dozen, including Connecticut, encompass treatment for substance use disorders.

State expenditures. In compliance with statutory requirements, DMHAS compiles information on all state agency substance abuse expenditures for its biennial report. The most recent available data on substance abuse spending by agency, which is for FY 05, is shown in Table II-3. The total expenditure information includes funding from all sources (state, federal, and other) for all three main categories of substance abuse services: 1) prevention, which encompasses education and non-clinical types of early intervention; 2) deterrence or law enforcement activities; and 3) treatment, which, for the purpose of the biennial report, is limited to services with a clinical component.

As Table II-3 indicates, the state's lead agency for alcohol and drug services, DMHAS, is responsible for the largest portion (57 percent) of all state agency substance abuse spending. Overall, about three-quarters of total state substance abuse spending is for treatment services. Two agencies, DMHAS and DSS, account for the bulk of state expenditures for substance abuse treatment (82 percent).

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[22] DMHAS 2006 Biennial Report, June 2007, p. 13.

[23] Dr. Thomas McLellan, Treatment Research Institute, PowerPoint presentation for Connecticut General Assembly Appropriations and Public Health Committees Informational Forum, January 23, 2008.

Table II-3. Substance Abuse Expenditures by State Agency: FY 05.*

	Total All Services	Treatment Services Only	Treatment as % Agency Total	Agency Treatment as % Treatment Total
Dept. of Mental Health & Addiction Services	$151,358,130	$128,862,295	85.1%	63.8%
Judicial-Court Support Services Division	$27,140,267	$10,856,107	40.0%	5.4%
Dept. of Children & Families	$17,341,290	$14,128,612	81.5%	7.0%
Dept. of Correction (includes Parole)	$10,616,883	$10,616,883	100%	5.3%
Dept. of Social Services	$37,175,576	$37,175,576	100%	18.4%
Dept. of Veterans Affairs	$397,873	$397,873	100%	0.2%
Other State Agencies**	$22,979,675	$0	0%	0%
Total	$267,009,694	$202,037,346	75.7%	100%

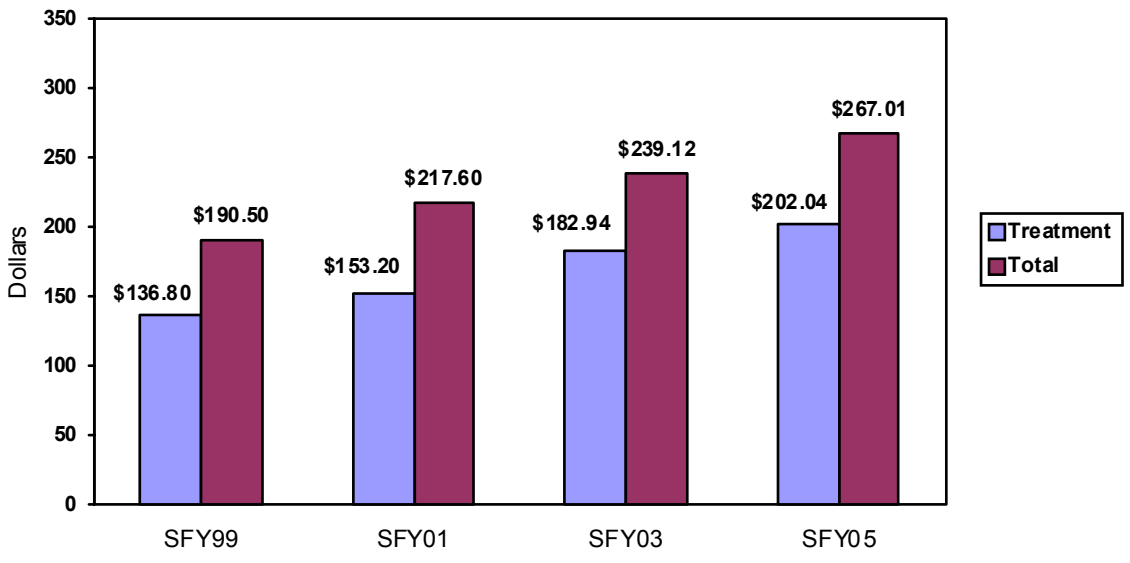
* Refer to explanatory footnotes in the source document for expenditure calculation methodology.
** Other state agencies include those that fund prevention and deterrence services but not treatment for alcohol and drug dependence (i.e., Departments of Education, Transportation, Public Health, and Public Safety, and the Office of Policy and Management).

Source of Data: DMHAS 2006 Biennial Report, June 2007, p. 27.

Among the agencies that fund treatment services, treatment accounts for all or most (almost 82 to 100 percent) of their substance abuse spending with one exception -- the Court Support Services Division of the Judicial Branch. Less than half of CSSD total expenditures for substance abuse services (40 percent) is identified as treatment spending. Many of the division's substance abuse services are prevention and non-clinical treatment interventions related to the statewide alternatives to incarceration network. For the purposes of the biennial report, non-clinical interventions are not considered to be treatment and, therefore, these CSSD services are categorized as prevention.

Statewide funding for treatment services and for substance abuse services in total over time is shown in Figure II-1. The figure shows there has been steady growth in state expenditures for treatment services, and for substance abuse services in total, since DMHAS began compiling funding information in 1999. However, according to the department, most of what appears to be a substantial increase over time is due to better expenditure reporting and the identification and inclusion of additional funding sources (e.g., Department of Social Services treatment expenditures have only been reported since FY 02). Improvements made in data collection will permit more reliable examination of spending trends in future biennial reports.

Figure II-1. State Substance Abuse Service Expenditures by Fiscal Year ($ in Millions)



Source of Data: DMHAS, 2006 Biennial Report, June 2007

Lead Agency: Department of Mental Health and Addiction Services

By law, DMHAS must coordinate all activities in the state relating to substance abuse treatment for persons age 18 and older, including those of other state agencies and the Judicial Branch. It is mandated to develop and implement a state plan for prevention, treatment, and reduction of alcohol and drug abuse problems. Furthermore, the department must establish "…comprehensive and coordinated programs for the treatment of alcohol-dependent, drug-dependent, and intoxicated persons…" consistent with the state plan. (See C.G.S. §17a-673.)

Responsibility for alcohol and drug abuse services has been within an integrated mental health and addiction services department since 1995, when all state substance abuse and mental health functions for adults were merged under the legislation that established DMHAS. Prior to the 1970s, authority and responsibility for substance abuse was within the former Department of Mental Health.

In 1977, the former Connecticut Alcohol and Drug Abuse Commission (CADAC) was created to plan, coordinate, and oversee publicly funded, primarily community-based, substance abuse prevention and treatment services throughout the state. In the late 1980s, CADAC assumed responsibility for state-operated substance abuse inpatient care from the state mental health department. CADAC's functions were transferred to a newly established Department of Public Health and Addiction Services under a 1993 public act and moved again in 1995 when the legislature eliminated that agency and created DMHAS.

Other legislation enacted in 1995 required the newly combined department to operate, within available appropriations, a behavioral health managed care program for individuals eligible for medical services under State-Administered General Assistance, or SAGA. This program, the General Assistance Behavioral Health Program (GABHP), began as a pilot and was made permanent in 1997.

At present, DMHAS, as the state's lead agency for adult behavioral services, is responsible for mental health and substance abuse prevention programs for all Connecticut citizens across their lifespan. The treatment services the department directly provides, or funds and monitors, are targeted to adults who lack the financial means to obtain services on their own DMHAS considers its treatment programs for substance abuse, as well as its mental health services, to be the "safety net" of the state's behavioral health system, provided to those without any other resources for obtaining care. (i.e., the publicly insured SAGA population and individuals without insurance or ability to pay).

Mission

The overarching mission of the Department of Mental Health and Addiction Services is to promote and administer: "… comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut." According to the department, its alcohol and drug treatment services are aimed at assisting recovery from substance use disorders while its prevention efforts promote factors that reduce the likelihood of substance misuse and abuse.

Current department leadership emphasizes the department's role as a healthcare agency focused on promoting wellness and improving the quality of life of individuals who receive DMHAS behavioral health services. Since the late 1990s, the agency has been working to integrate its mental health and addiction services and develop a recovery-oriented system of care.

The department defines recovery as: "…. a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within, the limitation imposed by that condition." According to the agency, this concept of recovery is the guiding principle and operational framework for its entire system of care, both state-operated and state-funded.

DMHAS began the process of transforming its system of care by asking client advocacy groups to help develop a set of core recovery values to guide future agency policy and operations. In 2002, the commissioner issued a written policy statement incorporating the 27 guiding principles resulting from this process; chief among them are the following :

- Services shall identify and build upon each recovering individual's strengths.
- The system shall encourage hope and emphasize individual dignity and respect.
- As recovery is a process rather than an event, services shall address needs over time and across different levels of disability.

- The system shall be notable for its quality, marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care, and sustained, rather than short-lived and crisis-oriented, effects.
- The system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact one's recovery.
- When possible, services shall be provided within the person's own community setting, using the person's natural supports.

Subsequent implementation strategies have included: additional formal policy statements to promote critical initiatives (e.g., serving those with co-occurring conditions); extensive provider training in recovery-oriented concepts and practices; and development and publication of recovery-oriented practice guidelines and standards. The department also has put in place recovery-oriented performance and outcome measures, a consumer feedback process, and a "technology transfer" program to promote use of recovery-oriented and evidence-based practices. Improvements in agency data systems are underway and the commissioner is committed to using new funding and realigning existing resources to promote recovery-oriented practice and programs.

Organization

Responsibilities related to substance abuse are carried out within many areas of the Department of Mental Health and Addiction Services. The organization chart presented in Figure II-2 highlights the department management positions with key roles for substance abuse treatment. The commissioner instituted a major reorganization of agency leadership and reporting authority in March 2008, which is reflected in the figure.

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As Figure II-2 indicates, there is no single division or unit within DMHAS dedicated soley to substance abuse treatment (or to mental health treatment). For the most part, agency managers responsible for key operations -- e.g., department treatment facilities, systems of care, community relations, medical issues, support services, fiscal, policy, research and planning, and forensic services (those related to the criminal justice system) -- carry out these functions for both mental health and substance abuse. In addition, the commissioner recently divided top level management responsibilities for the agency's behavioral health treatment system between the two deputy commissioners based on whether the services are state-operated or contracted.

At present, one deputy oversees all state-operated treatment facilities, and one oversees the agency's network of contracted treatment program providers, which is administered by the Health Care Services (HCS) Division. The latter deputy, who is considered to have primary responsibility for addiction services, also is in charge of ensuring that DMHAS is in compliance with all federal requirements related to its designation as the state methadone authority. [24]

[24] State statute requires there be two deputy commissioners for the department, both appointed by the commissioner, with one responsible for mental health and the other for addiction services.

State-operated facilities. The four facilities DMHAS operates that include substance abuse treatment programs are listed in Table II-4. Each one is headed by a chief executive officer who is responsible for day-to-day operations and overall management of programs and services. As the table shows, inpatient treatment for substance abuse is provided at three state behavioral health facilities, Connecticut Valley Hospital, Blue Hills Hospital, and Greater Bridgeport Community Mental Health Center. One agency-operated facility, Connecticut Mental Health Center, provides outpatient services for alcohol and drug dependency.

Table II-4. DMHAS-Operated Substance Abuse Treatment Facilities

Facility	Location	Substance Abuse Treatment Services
Connecticut Valley Hospital (CVH)	Middletown	• Inpatient detoxification • Residential rehabilitation
Cedarcrest Hospital -- Blue Hills Hospital Substance Abuse Division	Newington (Hartford)	• Inpatient detoxification • Residential rehabilitation
Greater Bridgeport Community Mental Health Center (Greater Bridgeport)	Bridgeport	• Inpatient detoxification
Connecticut Mental Health Center (CMHC)*	New Haven	• Outpatient program

* DMHAS operates CMHC in collaboration with the Yale University Department of Psychiatry

Source: PRI staff analysis

These department-operated programs represent only a small portion of the agency's alcohol and drug abuse treatment system. The bulk of DMHAS substance abuse (and mental health) services are delivered by contracted private providers on a regional basis, as described below.

Regionalized service network. State statute requires the commissioner to establish regions with the purpose of creating a regionalized system of comprehensive, community mental health and addiction prevention and treatment services. Currently, there are five DMHAS regions, as shown in Figure II-3. In accordance with state law, the department's contracted network of behavioral health services is planned and delivered, for the most part, on a regional basis.

Also by law, each region must be advised by a board composed of consumers, who must be the majority of the board's membership, and service providers within the region. Although called regional mental health boards (RMHBs), they are required by law to include "adequate representation" of individuals concerned with alcohol and drug services.

The RMHBs are responsible for: studying regional needs and developing plans to improve and increase services; reviewing and making recommendations about agency funding of services in the region; and reporting findings and recommendations about services in the region to the commissioner each year. Each regional board receives funding (about $105,500 in FY 08) from DMHAS that supports one or two staff positions to assist with these functions.

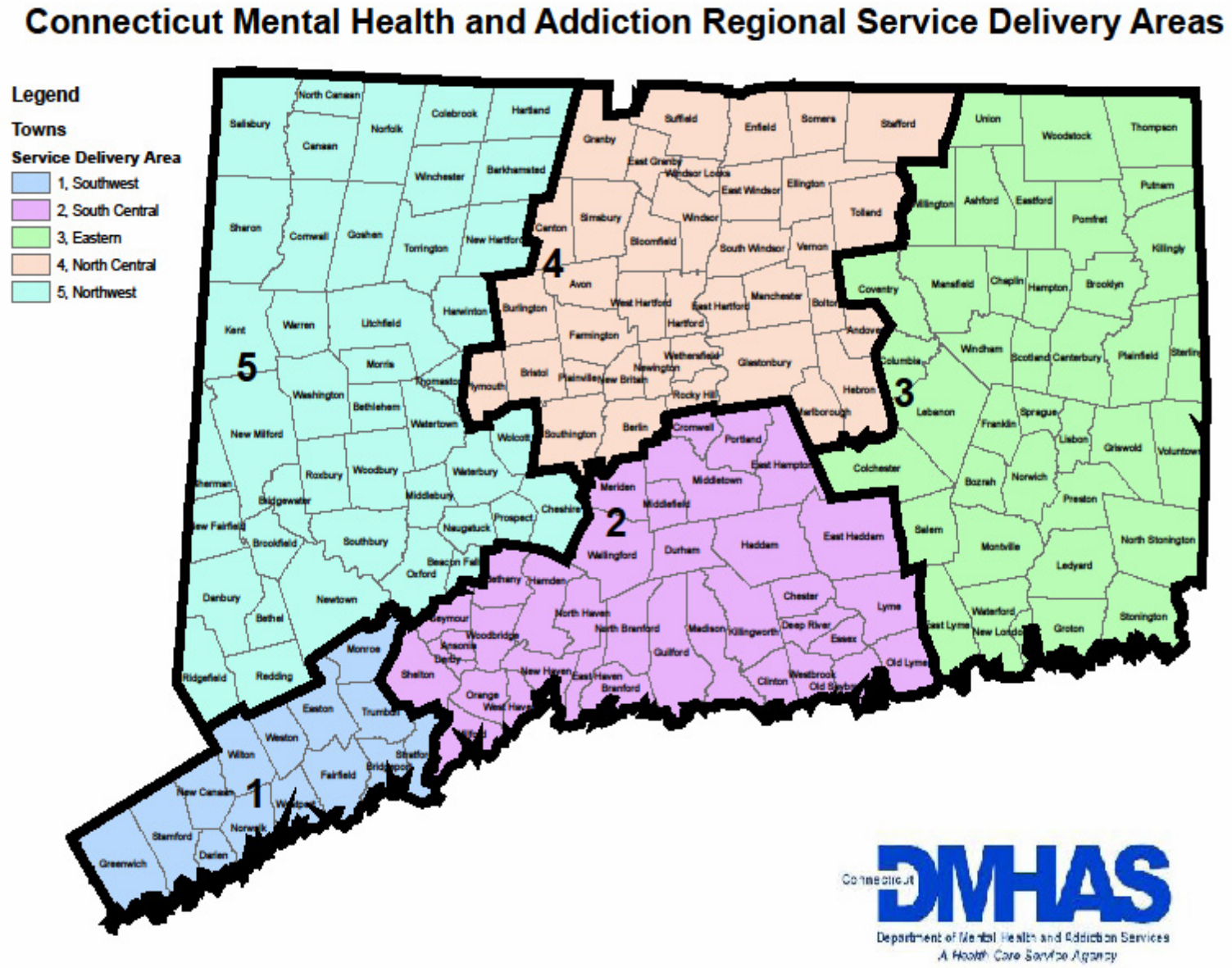
Health Care Systems Division. The department's Health Care Systems Division, staffed by 23 professional and two support personnel, has direct responsibility for overseeing all of the agency's contracted services. The division's two primary functions are: 1) managing the contracted private nonprofit providers that make up the agency's regional networks of behavioral health (mental health and substance abuse) services; and 2) overseeing the General Assistance Behavioral Health Services Program, the state's managed care system for mental health and substance abuse services for SAGA clients.

Regional teams. Small teams of two to three HCS staff are assigned to each of the DMHAS regions to manage and monitor contracted service providers. Each team is headed by a regional manager, all of whom report to the division director. At present, a total of 10 staff are assigned to four regional teams, with one team overseeing two regions and the other three responsible for one region each.

The main activities of the regional teams include:

- contract compliance (through desk audits and on-site reviews);
- provider monitoring (e.g., reviews of performance and regulatory compliance) and technical assistance;
- reviewing, negotiating, and making recommendations on provider funding applications;
- implementing new department services and initiatives; and
- identifying service gaps and developing new services (e.g., writing and reviewing requests for proposals for new or expanded programs).

Figure II. 3.


Connecticut Mental Health and Addiction Regional Service Delivery Areas
Legend
Towns
Service Delivery Area
1, Southwest
2, South Central
3, Eastern
4, North Central
5, Northwest
1
2
3
4
5
Connecticut DMHAS
Department of Mental Health and Addiction Services
A Health Care Service Agency

Regional teams also are responsible for "troubleshooting" -- resolving consumer and contractor problems -- and ensuring contractor providers meet all the agency's data reporting requirements.[25]

The HCS regional teams have responsibility for contract management functions related to substance abuse services procured from private providers. They also perform this role for mental health contracted services, although oversight responsibility is shared with DMHAS-operated local mental health authorities (LMHAs).

LMHAs. Before addiction services were merged with state mental health functions, the department had established local mental health authorities to manage systems of care for persons with serious and persistent psychiatric disabilities within specific geographic areas of each of the five regions. The LMHAs were designed to be the "clinical homes" for clients with chronic mental illness problems following deinstitutionalization of the department's hospital population in the 1980s.

At present, there are 14 LMHAs throughout the state; six are state-operated entities and eight are private nonprofit agencies that perform this role under contract to the department. They continue to serve as the main agency contact for DMHAS mental health clients within specific geographic service (catchment) areas. They act as a "clearinghouse" for the array of behavioral health services a client may require and also follow their clients through different levels of care for as long as they are attached to the DMHAS care system, even when individuals are treated outside of their catchment area (e.g., admitted to a statewide treatment facility like CVH).

LMHAs have outreach workers who identify individuals in need of mental health services, and help the identified clients access services. Staff also may determine client eligibility and some LMHAs also provide case management and treatment, such as outpatient services. However, the majority of services are provided by the LMHA affiliates, which are their contracted private nonprofit care providers. LMHA staff, in conjunction with their DMHAS regional management team, oversee their affiliates by monitoring compliance with contract provisions, reviewing performance, and assessing the need for new or expanded services.

There are no similar "umbrella" organizations coordinating care for the agency's substance abuse clients, except for adults covered by the state behavioral health managed care program, GABHP. Case management and care coordination efforts related to GABHP clients are discussed in more detail later in this chapter. For other DMHAS substance abuse clients, the programs providing care are responsible for coordinating services during the period of treatment. As a result, treatment can be more disjointed for adults receiving DMHAS alcohol and drug abuse services than for the agency's mental health clients.

Managed care program oversight. Currently, five staff of the Health Care Systems Division are responsible for overseeing the agency's behavioral health managed care program for the state's General Assistance clients. Their main responsibility is contract compliance monitoring of the private company hired to as the program's administrative services organization (ASO). The HCS staff duties also include procuring ASO services and developing and

[25] In accordance with state and federal law as well as contract provisions, DMHAS providers must report admission and discharge data, client demographics, and information on services delivered.

negotiating that contract, as well as developing and enforcing program regulations. In addition, all reports and information on program services the ASO is required to submit to DMHAS, such as monthly, quarterly, and annual utilization statistics and client demographics, are reviewed by division staff.

Forensic Services Division. Among the several divisions shown in Figure II-2 that report directly to the DMHAS commissioner is Forensic Services. Staff within this division are responsible for:

- collaborating with the state's law enforcement, judicial, and correction systems to implement and coordinate services for adults with serious mental illness or substance use disorders who are involved in the criminal justice system;
- providing, per state statute, specialized consultation and evaluation services to the courts (e.g., assessing competency to stand trial) and the state Psychiatric Security Review Board; and
- providing forensic risk management consultation to state-operated and private nonprofit provider programs in the DMHAS service system.[26]

The Forensic Services Division's collaborative activities involve a number of intervention programs, which have substance abuse treatment components, that are designed to meet two main goals:

- to divert people from the criminal justice system and into treatment for mental health and substance abuse problems; and
- to help people re-enter the community successfully after incarceration.

Many of the criminal justice diversion and re-entry programs, which are described briefly later in this chaptter, are carried out in conjunction with the Court Support Services Division of the Judicial Branch and the Department of Correction. At present, the division funds 96 full-time equivalent staff positions (52 state employees at community-based agencies and 44 staff within private nonprofit agencies) that provide direct client services related to 10 of its collaborative intervention programs for persons with behavioral health needs involved in the criminal justice system.

Systemwide Planning and Coordination

DMHAS is responsible for statewide substance abuse planning activities in accordance with both state and federal requirements. Under state statute, it must produce a comprehensive state substance prevention and treatment plan that contains long-term goals and objectives in consultation with community-based, regional planning and action councils (RACs). The

[26] Staff within the division currently total 34.6 FTE positions (30.5 are state employees and 4.1 are forensic psychiatrists under contract from Yale University Law and Psychiatry Department). Professional staff are also retained on a per diem basis for some court evaluations. The division's assistant director and six managers are responsible for the criminal justice collaborative activities.

department also must meet regularly with its state advisory board to review planning efforts. The state's regional substance abuse planning process and the state advisory board's role in planning is described briefly below.

Among the federal planning requirements related to substance abuse with which DMHAS must comply, is the Substance Abuse Prevention and Treatment Block Grant application process. The federal block grant process requires a comprehensive planning and needs assessment effort with public participation and evidence of interagency coordination and collaboration. State law also directs DMHAS to coordinate state substance abuse treatment activities and to collaborate with other agencies in planning and delivering services. To accomplish this task, the department participates in several groups aimed at improving communication and cooperation across state agencies and system. Descriptions of two such groups 8that focus on substance abuse treatment matters, the Alcohol and Drug Policy Council (ADPC) and the Criminal Justice Policy Advisory Commission (CJPAC), are included below

In recent years, DMHAS has initiated a regional priority setting process as a foundation for comprehensive, unified planning for behavioral health services. This process draws upon the extensive, existing mental health and substance abuse planning, advisory, and advocacy structure in the state. The department relies on the RMHBs and RACs to facilitate the needs assessment process in each region to determine service gaps regarding both mental health and substance abuse treatment and prevention needs. The agency intends the process to be an ongoing method for obtaining regional input and broad stakeholder perspectives on behavioral health priorities.

State substance abuse planning. Under state law, regional and subregional organizations called planning and action councils (RACs) are responsible for planning and coordinating state substance abuse prevention and treatment activities. At present, there are 14 councils designated within the five DMHAS service regions. (See Appendix B, which presents an overview of the department's regional structure.) Separate statutorily required organizations, known as Catchment Area Councils (CACs), carry out similar planning functions regarding mental health services. The CACs work in conjunction with the Regional Mental Health Boards, discussed earlier, to advise the department in planning, evaluating, and implementing community-based behavioral health services.

The RACs are public-private volunteer organizations that, by statute, must represent: local community leaders (e.g., chief elected officials, school superintendents, business executives, and state legislators); major service providers and funders; and minority populations, religious organizations, and the media. The councils are prohibited by law from providing any direct services to clients. Their main duties related to substance abuse service planning and coordination are to:

- identify gaps in the continuum of care, which includes community awareness and education, prevention, intervention, treatment, and aftercare;
- develop and submit to DMHAS an annual action plan to address service gaps;
- conduct fund-raising activities to fill identified gaps; and
- carry out activities to implement plan initiatives and promote council visibility.

DMHAS provides funding to support their core administrative functions for substance abuse planning (about $1.6 million total in FY 08) and for the councils' prevention coordination activities.

State board. By law, the agency's statewide advisory group, the Board of Mental Health and Addiction Services, meets monthly with the DMHAS commissioner to review and advise the agency on its programs, policies, and plans. Its other statutory duties include:

- advising the governor on candidates for DMHAS commissioner;
- issuing periodic reports to the governor or commissioner;
- advising and assisting the commissioner on program development and community mental health or substance abuse center construction planning; and
- serving as the state advisory council to DMHAS in administering the state's mental health and substance abuse programs.

The state board is broadly representative of behavioral health services stakeholders. Its members must include: mental health and substance abuse treatment professionals; representatives of consumers, their families, and advocacy groups; and designees of various regional planning entities, including RACs. Board members may include others interested in the state mental health and substance abuse system but no more than half of the members can be service providers. The board selects its own chairperson and other officers, may establish rules for its internal procedures, and may appoint nonmembers to serve on ad hoc advisory committees as it deems necessary.

ADPC. The Connecticut Alcohol and Drug Policy Council has a primary role in coordinating substance abuse policies across state agencies and all three branches of government. First established by executive order in 1996 in response to recommendations of a gubernatorial task force on substance abuse, the council was made statutory in 1997. Its members are executive, judicial, and legislative branch officials or their designees; by law, the DMHAS and DCF commissioners serve as co-chairs of the council. OPM, within available appropriations, provides staff for the council.

Since its creation, ADPC has had responsibility for overseeing state substance abuse treatment and prevention policies and programs. It is required by law to review policies and practices of state agencies and the Judicial Department concerning: substance abuse treatment and prevention programs; referral to such programs and services; and criminal justice sanctions and programs. State statute further requires the council to "… develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions." Each year, by January 15, the council must submit a report to the governor and the legislature evaluating progress in implementing its plan and recommending proposed changes to substance abuse policies and programs.

The council's current plan at the time of this study, which was issued in January 2007, identified four issues as top priorities at the national, statewide, and regional levels based on the council's research and input from stakeholders. They are: underage drinking; tobacco cessation; buprenorphine; and adolescent substance abuse treatment. The ADPC plan also outlines a series of recommendations for legislative action and state agency policy and procedures regarding each of the four areas of concern.

CJPAC. The Criminal Justice Policy Advisory Commission was created in 2006 as the successor to the state's Prison and Jail Overcrowding Commission. Its main purpose is to examine issues related to prison overcrowding and promote collaborative efforts to address the problem. The commission consists of 12 executive and judicial branch officials, including the DMHAS commissioner, and eight gubernatorial appointees who represent various interested parties, such as local police chiefs, providers of community services for offenders, and victims, as well as the general public.

CJPAC's primary duties are to:

- develop and recommend policies for preventing prison and jail overcrowding;
- examine the impact of current policies and research efforts to prevent prison and jail overcrowding, and make this information available to criminal justice agencies and the legislature; and
- advise OPM's Criminal Justice Policy and Planning Division on policies and procedures to promote an effective and cohesive criminal justice and juvenile justice system and the statutorily required offender reentry strategy.

CJPAC is required by statute to have a behavioral health subcommittee that includes, among others, representatives from the Departments of Correction and Mental Health and Addiction Services. The subcommittee is charged with making recommendation concerning the provisions of mental health and substance abuse treatment to inmates. DMHAS also has had a major role in the commission's work to promote successful community reentry by better linking newly released inmates to behavioral health treatment and support services.

Collaborative contracting. A collaborative contracting project initiated in 2005 at the direction of the Office of Policy and Management is another way DMHAS promotes coordination of substance abuse treatment across state agencies. Under the project, the department coordinates procurement of more than 250 residential beds for adult alcohol and drug abuse treatment from 12 different private providers that, in the past, were purchased individually by DMHAS, CSSD, and DOC.

The two main goals of the collaborative process are: more efficient management of shared, private nonprofit treatment resources; and reduced administrative burden for the provider agencies that operate the contracted residential treatment services. The joint steering committee that operates the project is considering expanding the process to other services, beginning with certain types of outpatient treatment.

DMHAS Treatment Resources

The best available estimate of agency resources allocated to treatment for alcohol and drug abuse is the expenditure information DMHAS develops for the statutorily mandated biennial report on state substance abuse activities. The most recent report shows the department spent $128.8 million on alcohol and drug abuse treatment for adults in FY 05. This amount represents about one-quarter of the agency's total budget for that fiscal year ($520 million) and accounted for almost two-thirds of spending on substance abuse treatment by all state agencies in FY 05 ($202 million).

Current staffing information indicates about 10 percent of the DMHAS workforce is assigned to the agency-operated substance abuse treatment programs. As of May 2008, 404.3 of the 4,048.4 total full-time equivalent positions at the department were clinical and support staff for the inpatient and outpatient substance abuse treatment programs at DMHAS facilities. The number of agency staff involved in planning, coordinating, procuring, and overseeing community-based alcohol and drug abuse treatment (versus mental health) services funded by DMHAS could not be determined within the study timeframe.

Similarly, total direct and indirect costs for agency-operated and contracted substance abuse services could not be calculated for the purposes of this study. Expenditure data for DMHAS inpatient substance abuse treatment programs were available and estimated at $42 million for FY 08. Direct spending on the substance abuse service grants DMHAS provides to private nonprofit organizations for community-based treatment programs totaled roughly $28 million for the same fiscal year.

PRI staff worked with the department to develop information on all agency funding and staff positions allocated to its substance abuse treatment activities that could be used to analyze the state's costs by type of service, client population, provider, and over time. Agency fiscal staff were able to develop some preliminary cost figures for selected levels of care provided under the DMHAS-administered behavioral health managed care program for General Assistance clients. Further analysis was planned but the department did not expect to have more comprehensive results available until sometime after completion of the program review committee study, due both to data collection needs and limited staff resources.

DMHAS Treatment Programs and Services

The Department of Mental Health and Addiction Services maintains a regionalized, comprehensive substance abuse treatment system for its clients that is composed of four main components: *community treatment*, which includes emergency services and outpatient programs; *residential treatment*, which encompasses a wide range of 24-hour care and supervision; *inpatient services,* provided at department-operated facilities; and *recovery supports*. In addition, it carries out a number of special programs and initiatives targeted to particular client groups or substance abuse problems.

According to DMHAS, all of its treatment modalities and programs for alcohol and drug dependent clients are intended to focus on the following service priorities:

- medical management of withdrawal from alcohol or drugs;
- residential services that impact significant levels of dysfunction;
- ambulatory services that help individuals re-enter or remain in the community; and
- for opiate addicted persons, opioid replacement therapy along with supportive rehabilitative services.[27]

Available information about each component of the DMHAS substance abuse treatment system and several major initiatives is highlighted below.

System overview. As noted earlier, DMHAS contracts for the majority of substance abuse treatment services its clients receive. With the exception of the detoxification and rehabilitation programs at the department's three inpatient facilities, and the outpatient services for alcohol and drug dependency available at one of the agency's community mental health centers, all clinical treatment and recovery support services are provided through contracted providers, who are primarily community-based, nonprofit agencies. Currently, the department funds about 180 different private programs that provide clinical services including detoxification, outpatient services, and residential treatment.

All contracted programs providing clinical services must be licensed as substance abuse treatment facilities by the Department of Public Health. The DMHAS facilities that provide substance abuse treatment, while not DPH licensed, are nationally accredited by the Joint Commission.[28]

DMHAS also encourages, but does not require, its contracted service providers, as well as its own treatment programs, to use evidence-based treatment modalities and to follow preferred practices standards. The agency offers training on the foundations of evidence-based practices for private provider staff and its own employees and provides courses on several specific evidence-based practices (e.g., cognitive behavioral therapy and motivational interviewing). As noted earlier, the department provides training, and issued guidelines, on its recovery-based practice standards for staff of all agency-operated and contracted treatment programs.

Clients served. Over the past four years, the department's substance abuse treatment system has served over 35,000 adults annually. As Figure II-4 shows, the total number of clients receiving services has grown each year and increased about 8 percent from FY 05 to FY 08. (Numbers for FY 08 were still estimates at this time of this study.)

The numbers of active clients presented in the figure include all persons admitted to treatment at a state-operated or funded program in the reported year, or admitted in a prior year but still receiving clinical services for substance abuse (e.g., detoxification, residential treatment, and outpatient services including methadone maintenance), regardless of their payment source.

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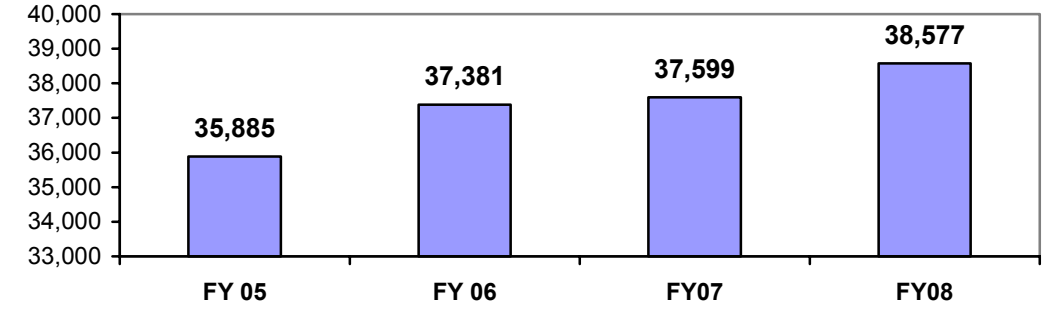
[27] DMHAS federal Substance Abuse Prevention and Treatment (SAPT) block grant application, 2007.

[28] The Joint Commission, formerly the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), is a national, nonprofit organization that accredits a variety of types of health care facilities throughout the U.S.

It does not include persons only receiving evaluations or support services (e.g., case management, vocational, employment, and educational services, and housing assistance).

Figure II-4. Number of Persons Served by DMHAS Substance Abuse Treatment System



Source of Data: DMHAS

DMHAS does not maintain formal wait lists for any of its services, as they proved to be unreliable and difficult to manage in the past. Instead, it relies on its regional planning process to identify unmet treatment needs, gaps in services, and underserved populations. In addition, the agency is working on building utilization management capability through ongoing improvements to its automated information systems.

Community treatment services. Within the department's service system, both emergency or crisis services and all outpatient programs, including methadone maintenance, are considered community treatment services. Emergency/crisis services assess and treat adults with acute psychiatric or substance use disorders, or both, to stabilize their conditions, prevent hospitalization when possible, and arrange for further treatment when necessary.

These services are available 24 hours a day, seven days a week at general hospital emergency departments and walk-in clinics supported by mobile crisis teams of emergency workers operated or funded by the agency. At present, 15 mobile crisis teams provide services to alcohol and drug dependent persons in need of emergency care.

As noted earlier, DMHAS provides some outpatient substance abuse treatment at its Connecticut Mental Health Center facility located in New Haven. However, most of the wide array of outpatient services for the agency's clients with alcohol and drug dependence problems are provided by contracted private nonprofit providers. Health professionals employed by the outpatient program providers evaluate, diagnose, and, in regularly scheduled visits, treat clients through medication and behavioral therapies.

At present, outpatient services funded by the department include: intake and evaluation; regular and intensive outpatient therapies; partial hospitalization; and ambulatory detoxification and methadone maintenance and other opiate replacement therapies. Data on the number of clinical outpatient treatment programs and their capacity is shown in Table II-5.

Table II-5. DMHAS-Funded Outpatient Clinical Treatment Services: September 2008.		
	NUMBER PROGRAMS	CAPACITY
Regular Outpatient (OP)	94	5,401
Intensive Outpatient (IOP)	55	542
Partial Hospitalization (PH)	21	361
Ambulatory Detoxification	21	456
Methadone Maintenance (MM)	24	9,168
Source of Data: DMHAS		

As the table shows, most of the department's outpatient service capacity is concentrated in traditional (regular) outpatient treatment and methadone maintenance programs. DMHAS estimates in FY 08, the number of substance abuse clients receiving regular outpatient treatment totaled 18,719; another 12,523 participated in methadone maintenance treatment.

Residential treatment. The department contracts for a full array of residential treatment services for clients with substance use disorders ranging from the most intensive type of residential treatment, medically managed detoxification, to the least intensive level of residential care, which is provided in halfway house settings. Halfway houses provide 24-hour supervision, along with some clinical treatment (e.g., counseling) and recovery supports, to help clients prepare to transition to independent living arrangements.

Residential treatment programs funded by DMHAS, in addition to intensive detoxification and halfway houses, include a continuum of rehabilitative care of varying duration (e.g., short-term, intermediate, and long-term) and intensity. For example, some programs offer treatment through a very structured, therapeutic community environment, while others provide daily therapy in a relatively independent living setting. Data on the different types of residential treatment programs for alcohol and drug abuse that are funded by DMHAS are shown in Table II-6. As described below, the department also directly provides some of the most intensive residential treatment services available in the state (medically managed detoxification and rehabilitation) at its inpatient facilities.

Table II-6. DMHAS-Funded Residential Treatment Services, September 2008.		
	NUMBER PROGRAMS	CAPACITY
Medically Managed Detoxification*	2	6
Residential Detoxification	7	126
Long-Term Care and Rehabilitation	1	50
Intensive Residential Treatment	11	226
Intermediate/Long-Term Residential Treatment	20	859
Halfway Houses	8	93
*Medically managed detoxification also is provided and paid for under the GABHP program at medical units in 14 general hospitals (no fixed capactiy). Source of Data: DMHAS		

State-operated inpatient services. Information about the department's three inpatient facilities is summarized in Table II-7. As the table indicates, all three facilities provide medically managed detoxification services and two (CVH and Blue Hills) also operate residential rehabilitation programs.

Table II-7. DMHAS-Operated Inpatient Substance Abuse Treatment Programs, FY 08.

	Connecticut Valley Hospital Addiction Services Division	Blue Hills Hospital Substance Abuse Services	Greater Bridgeport Addiction Services Division
	Detox and Rehab	***Detox and Rehab***	***Detox (only)***
Number Beds	110	42	20
Patient Days*	40,398	14,149	6,421
Unduplicated Clients*	1,616	1,205	510
Operating Budget	$25.981 million	$8.412 million	$5.057 million

* These statistics for FY 07
Source of Data: DMHAS and Governor's Budget, 07-09 Biennium

Recovery supports. There is substantial research showing successful recovery from substance use disorders is promoted when effective treatment is combined with client supports such as housing, transportation, and employment assistance, and social and other supplemental services. (See the earlier discussion of treatment effectiveness in Chapter I.) To promote recovery, DMHAS make a wider range of community-based support services available to clients suffering from substance use disorders, or mental illness, or both.

At present, the department's continuum of recovery support services include:

- case management, which helps clients maintain their recovery by identifying their needs, developing plans for meeting them, linking them with community-based services, and monitoring their progress;
- rehabilitation services that promote employment and skills necessary for independent living (e.g., vocational, educational, daily living, interpersonal, and life management skills);
- short-term housing assistance (including sober housing);
- transportation services;
- vouchers for basic needs (i.e., food, clothing, toiletries); and
- peer- and faith-based supports.

The main sources of recovery supports for the department's clients with substance use disorders are two special programs described in more detail below: the federally funded Access to Recovery (ATR) and the Recovery Supports component of the General Assistance Behavioral Health Program.

Special programs and initiatives. DMHAS carries out special substance abuse treatment programs targeted to certain populations (e.g., individuals involved in the criminal

justice system) or particular treatment needs (e.g., co-occurring disorders). These initiatives, which often are funded through federal grants and conducted in collaboration with other state agencies and organizations, are highlighted below.

Criminal justice collaborative projects. For a number of years, DMHAS has been working with law enforcement agencies, the Judicial Branch, and the Department of Correction to help ensure individuals with severe mental illness, substance use disorders, or both, receive appropriate behavioral health services when they are involved with the criminal justice system. The purpose of many of the department's joint efforts with criminal justice agencies is: to reduce recidivism by diverting persons with substance use disorders from the courts and correctional facilities into treatment and recovery; and to promote successful reentry into the community by providing substance abuse treatment and recovery supports to individuals with alcohol and drug abuse problems when they are released from prison.

At present, the agency's Forensic Services Division is participating with CSSD in three pre-trial diversion programs that specifically serve adults with substance abuse problems involved in the criminal justice system. The target population for 10 other collaborative criminal justice intervention programs is adults with serious psychiatric and co-occurring disorders. All of the division's collaborative programs are described in more detail in Appendix C.

As the appendix indicates, the majority of the programs operate at a limited number of sites and some serve relatively small numbers of clients. Many of the programs are supported with federal grant funds. As a result, they often involve evidence-based practices and were or are subject to an independent evaluation of their effectiveness. (Outcome data concerning substance abuse treatment services provided through the collaborative criminal justice programs reviewed by PRI staff during this study are summarized in Chapter VI.)

Access to Recovery. The department's Access to Recovery program began in 2004 under a three-year, $22.8 million federal grant. The federal grant was aimed at: expanding treatment and recovery supports for clients with substance use disorders; creating relationships between clinical and nonclinical service providers; and promoting collaboration among agencies and systems involved with substance abuse clients. Funding could be used for a variety of services and supports, including: housing, transportation, and vocational/educational services; case management; faith- and peer-based support services; basic needs; and certain types of substance abuse treatment (e.g., intensive outpatient, methadone maintenance, and brief treatment). DMHAS received another multi-year grant award ($14.5 million) in June 2007 to continue a second phase of the program.

Under the first phase of ATR, DMHAS worked with four other agencies (DOC, CSSD, DSS, and the Department of Children and Families) to provide alcohol and drug dependent clients access to a portfolio of recovery-oriented services, both clinical and nonclinical. Many of the recovery supports were evidence-based practices and program outcomes were monitored and evaluated by Yale University.

Over the three-year grant period, the program served over 18,000 unduplicated clients, with about half coming from CSSD and DOC. Through ATR, DMHAS also established five regional recovery support networks representing 34 clinical treatment providers and 88 recovery

support services agencies. The Yale evaluation showed, overall, the combination of clinical and recovery supports services had better outcomes (decreases in substance abuse and jail time/arrests, increases in stable housing, and employment) than clinical treatment alone.

Co-occurring disorders projects. Since the 1990s, DMHAS has been involved in a number of initiatives intended to improve services for adults with co-occurring disorders. These include its dual diagnosis task force in 1997 and a series of academic research partnerships (e.g., with Yale, Dartmouth, and the University of Connecticut) aimed at determining prevalence, developing diagnostic tools, and assessing treatment practices for dual disorders/co-occurring conditions. In 2005, the department received a five-year, $4 million federal grant (Co-Occurring State Improvement Grant) to help implement integrated services for people with co-occurring mental health and substance abuse disorders statewide.

DMHAS is using the grant funding to accomplish three main goals: implementation of standardized screening measures (see intake process discussion, below); information sharing and network building for integrated service delivery; and data-based decision making (e.g., development of reliable estimates of the prevalence of co-occurring disorders to inform planning efforts). In conjunction with the grant project, the Dartmouth medical school is providing training and technical assistance to treatment providers who are trying to integrate their services for clients with co-occurring conditions. Yale University is monitoring and evaluating the outcomes of the agency's activities.

General Assistance Behavioral Health Program. The General Assistance Behavioral Health Program provides mental health and substance abuse treatment for people who receive medical benefits through the State-Administered General Assistance Program. Under the program, some clients also can receive case management services and basic needs assistance to support their treatment and recovery process.

Responsibility for SAGA behavioral health services was transferred from the Department of Social Services (DSS) to DMHAS in 1998. (DSS is still responsible for SAGA medical benefits *other* than mental health and substance abuse treatment services.) DMHAS designed the program as a public-private partnership, fee-for-service system. It contracts with an administrative services organization to perform operating functions including: credentialing of providers; claims management, processing, and payment; and utilization management. Authority for all policy decisions related to the program rests with DMHAS. As noted earlier, staff of the department's Health Care Systems Unit oversee administration of the program and monitor Advanced Behavioral Health, the program's ASO.

Under the program, clients can receive a full array of behavioral health treatment and recovery supports, subject to utilization management and prior authorization. Appendix D outlines the program's levels of care and model for utilization management. The model is based on the department's standardized client placement criteria discussed later in this chapter.

Basic information on treatment services provided to GABHP clients over the past two fiscal years is provided in Table II-8. As the table indicates, the majority of the SAGA clients eligible for behavioral health services received treatment for substance use disorders. Just over

70 percent in FY 07, and about 67 percent in FY 08, of the more than 23,000 individuals served annually under the program were provided treatment for alcohol and drug abuse problems.

Table II-8. Persons Served by DMHAS GABHP, FY 07 - FY 08.		
	FY 07	**FY 08**
Total Individuals Served	23,762	23,820
Number Receiving Mental Health Treatment Services	9,978	10,957
Number Receiving Substance Abuse Treatment Services	16,863	16,053
Source of Data: DMHAS		

Under a part of the program called Recovery Supports, GABHP clients can receive temporary assistance for housing (e.g., independent apartment, congregate sober housing, security deposit, and utilities) and transportation (e.g., bus pass, livery, and gas card) as well as vouchers for basic needs such as food, clothing, and personal care items. These support services are intended to help people remain in treatment while promoting recovery, independence, employment, self-sufficiency, and stability. Recovery Supports, like the GABHP clinical treatment services, are managed by the program's ASO.

Eligibility is limited to individuals who do not receive SAGA cash benefits (or other income) and who are receiving or attempting to enter treatment at a mental health or substance abuse facility. Clients can apply for the program through their treatment provider or a recovery specialist; if approved, they receive assistance (e.g., vouchers for basic needs items) on a monthly basis for up to three months.

Case management services also are available for some GABHP clients through a program called Intensive Recovery Supports. It provides additional support for clients having great difficulty maintaining their recovery and meeting their treatment goals as evidenced by frequent readmissions to inpatient treatment (e.g., detoxification or psychiatric hospitalization).

The department has used the GABHP intensive case management program to address the needs of opiate addicted clients with numerous, repeat admissions to certain detoxification services. Through an initiative called the Opiate Agonist Treatment Program (OATP), staff of the department's ASO identify "high utilizers" of expensive, residential detoxification (e.g., those with three detoxification episodes in six months) for opiate abuse and educate them about treatment alternatives, such as methadone maintenance, long-term methadone detoxification, or abstinence in conjunction with long-term residential treatment. Individuals who decide to enter OATP are given priority admission to the alternative service they select and intensive case management is provided to arrange "wraparound" services such as housing, vocational, and educational opportunities to support their recovery.

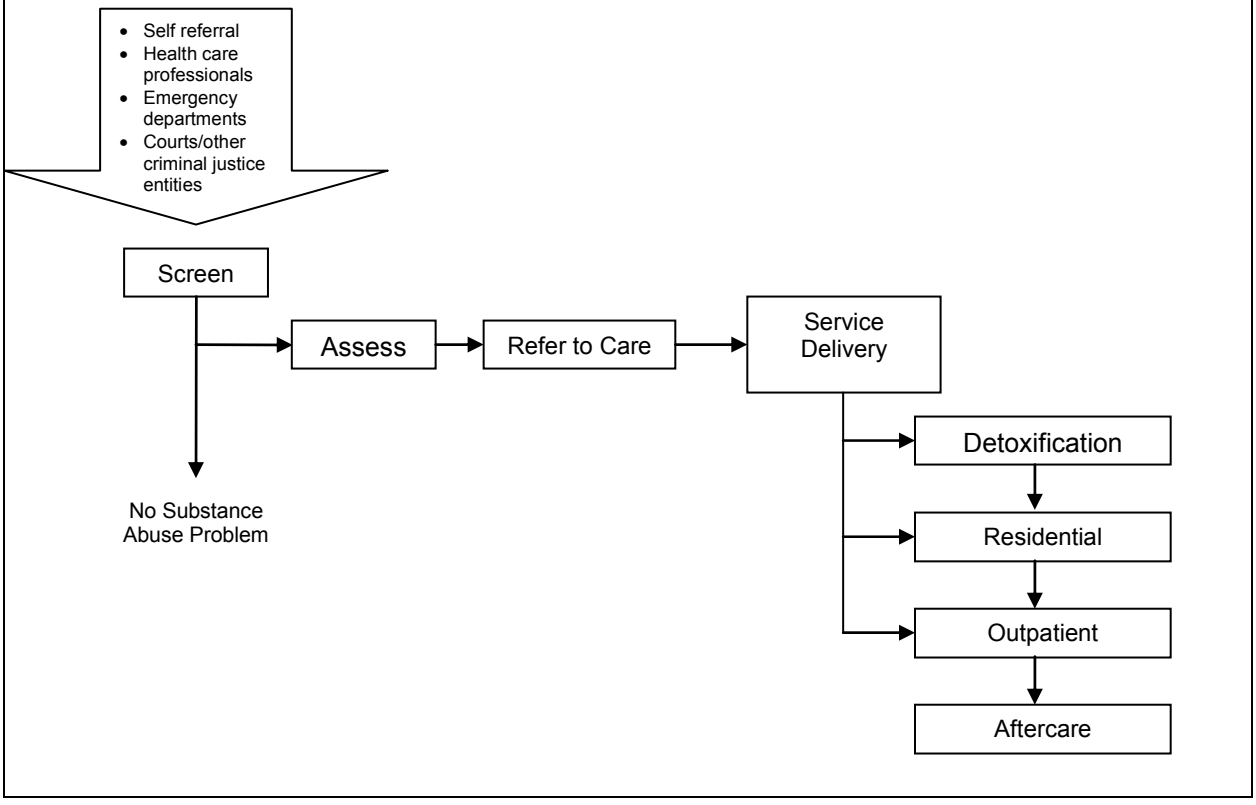
The OATP program began as a pilot in state-operated facilities and following a positive assessment of program outcomes, was expanded to other detoxification service providers. Research showed participation in the program significantly reduced use of detoxification and inpatient care and favorably increased a client's connection with less intensive and expensive

care following discharge from detoxification. Overall, OATP has been credited with a marked decrease in use of residential detoxification services throughout the state and more efficient and effective management of that costly level of care. The department is considering a similar program for individuals with repeated admissions for alcohol detoxification.

DMHAS Intake and Assessment Process

The main steps in the process typically followed in providing substance abuse treatment services are illustrated in Figure II-5. As the figure indicates, clients can come into substance abuse treatment in several ways. DMHAS clients, for example, may enter the state system: on their own initiative due to concerns about their alcohol or drug use problem; through screening and referral by a physician or another health care professional in the community; or because of involvement with the criminal justice system. State statute also provides for an involuntary commitment process for individuals with behavioral health problems that is overseen by the probate courts.

Figure II-5. Substance Abuse Treatment Process: Main Steps



Under the involuntary commitment process, alcohol or drug dependent persons who meet certain criteria (e.g., dangerous to self or others, or at risk of potentially life-threatening withdrawal symptoms) can be admitted for emergency treatment without their consent under what is called a physician's emergency certificate (PEC). According to DMHAS, a PEC for an adult needing substance abuse treatment is rare. In general, involuntary commitments to agency

services are infrequent and most cases involve individuals with serious psychiatric problems rather than alcohol or drug dependency.

Intake. Individuals seeking DMHAS substance abuse treatment services, from either a state-operated or contracted program, are subject to the same intake process. Intake involves two main steps: screening and assessment. Screening identifies the person's risk of having a substance use disorder. It determines whether or not a person has a particular substance abuse problem that warrants further attention at the current time; it does not result in a diagnosis.

The assessment step is carried out for individuals who are found to be at risk ("screen positive') for alcohol or drug dependency. It identifies the specific problem and its severity. Assessment involves a professional evaluation to develop a diagnosis and recommendations for appropriate care and placement. As described below, DMHAS has established standardized screening tools and placement criteria that all substance abuse treatment programs it funds or operates must use.

Screening. Standardized screening of potential clients is a widely recognized best practice encouraged by SAMHSA. Since July 1, 2007, all DMHAS programs, whether agency funded or operated, are required to use standard screening measures for substance use and mental health problems for all treatment program admissions.

Under department policy, treatment providers can choose from two types of mental health screening instruments and two substance use screening instruments, which are listed in Table II-9. The screening measures were selected by a workgroup of treatment providers and agency staff responsible for a DMHAS initiative on co-occurring disorders. All four are validated instruments widely used in other states and endorsed by SAMHSA and a national center for excellence on co-occurring conditions.

Table II-9. DMHAS Standardized Screening Measures

Mental Health	Substance Use
Mental Health Screening Form-III (MHSF-III)	Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
Modified Mini International Neuropsychiatric Interview (Modified Mini)	CAGE-Adapted to Include Drugs (CAGE-AID)

Source of Data: DMHAS, http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=392802 , Screening Measures website, accessed 9-26-2008

Providers must use one of each type, unless it would be medically or clinically inappropriate, or for a specific exception listed in DMHAS policy (e.g., for pretrial intervention or jail diversion programs). Each of the screens involve a series of yes-no questions, which the department recommends be asked in a face-to-face interview. Self-administration is allowed but not preferred. It is estimated the screens take about 10 minutes to administer.

According to department policy, all programs should establish written protocols for their screening procedures that include but are not limited to: how the screens will be administered and by whom; next steps to take based on screening results (e.g., arranging an assessment,

referrals to make if a person answers yes to questions on suicidal thoughts); and what additional screening information should be collected (e.g., toxicology).

Any staff member trained on the measures can administer them, but department guidelines recommend clinical personnel oversee any screening done by nonclinical staff. Clients who receive a positive score on any of the screens should receive a comprehensive assessment by appropriate staff. Clients, however, can choose not to have an assessment done.

Screening data must be reported to DMHAS and can be submitted electronically. The agency's automated information systems for department-funded providers (DPAS) and for department-operated facilities (BHIS) both allow treatment program staff to enter directly an individual's score from each screen administered, along with other clinical and demographic information.

Assessment. For the most part, clients are assessed where they present for treatment services. DMHAS requires that clients receive a comprehensive biopsychosocial assessment by appropriate staff to develop a treatment plan and a recommendation for appropriate level of care (a placement decision). A biopsychosocial assessment evaluates a person's physical and psychological status, social and emotional resources, including support systems, and any other contributing factors needed to make a diagnosis and placement decision.

Appropriate staff means treatment professionals who are authorized under state public health department regulations to make a diagnosis, such as doctors, nurses with advance practice credentials (APRNs), licensed clinical social workers, and certain other licensed or certified therapists and treatment professionals. Such individuals have been trained in applying the diagnostic criteria for substance use disorders contained in the Diagnostic and Statistical Manual of Mental Health Disorders (the DSM), which is the medical profession's clinical guide to psychiatric care. Under DMHAS contracts and DPH licensing standards, as well as national accreditation standards, substance treatment providers must have appropriate staff available to carry out assessment and diagnosis functions, either within their programs or on a referral basis.

The department does not require its own treatment programs or its contracted providers to use a particular assessment tool, although there are a number of validated instruments available. In contrast, several of the more commonly used standardized assessment instruments for substance use disorders (e.g., the ASI and ASUS) are mandatory components of the intake process for substance abuse treatment in other state agencies, as the following chapters describing CSSD and DOC describe.

Placement criteria. DMHAS requires all placement decisions for substance abuse treatment it provides or funds be made in accordance with the department's standardized Connecticut Client Placement Criteria (CCPC). Standardized placement criteria are recognized as one of the essential elements for better quality, and more efficient, treatment services. A workgroup of agency staff and representatives of private providers developed the CCPC after reviewing criteria used in other states and the patient placement criteria developed by the American Society of Addiction Medicine (ASAM). The agency's final criteria, which were adopted in 1997, are a combination of the ASAM criteria and a Connecticut-specific supplement.

As Table II-10 shows, the Connecticut Client Placement Criteria encompass four levels of treatment of increasing intensity; within each level, there also is a range of care.[29] The CCPC provides detailed guidelines for placing clients that correspond to DSM diagnostic criteria and take into account the following considerations: acute intoxication/withdrawal; biomedical conditions; emotional and behavioral conditions; acceptance of treatment; relapse potential; and recovery environment.

DMHAS providers are required to base their admission, continued stay, and discharge decisions for all clients treated on these criteria. According to the department, in applying the criteria, individuals presenting for treatment are matched to the least intensive level of care that is appropriate, and then "stepped up" to more intensive treatment settings if they do not respond. If the provider performing the assessment and applying the CCPC does not have the appropriate level of care available, then placement must be coordinated with a provider that does. Overall, the department's four main objectives of its CCPC clinical protocols are to:

- improve access by coordinating entry to services;
- assist decisions for placement in the least restrictive and most appropriate setting;
- provide statewide consistency; and
- identify service gaps for future service development.

Table II-10. CCPC Levels of Care for Substance Use Disorders

Level 1 Outpatient	Level 2 Intensive Outpatient	Level 3 Residential/Inpatient	Level 4 Hospital-Based
• Outpatient - Drug free • Methadone Detox. • Methadone Maintenance	• Ambulatory Detox. • Intensive Outpatient • Opioid Maintenance Therapy • Partial Hospitalization	• Clinically Managed Low Intensity Residential • Clinically Managed Medium Intensity Residential • Clinically Managed Medium/High Intensity Residential • Medically Monitored Inpatient Detox. • Medically Monitored Intensive Inpatient • Medically Managed/ Monitored Inpatient Services	• Observation Bed • Medically Managed Inpatient Detox.

Source of Data: DMHAS Connecticut Client Placement Resource Packet , Jan. 1, 1997

[29] The full CCPC includes one additional care level, Level .5 Prevention, which includes clinical prevention services.

Treatment planning. In addition to determining appropriate care level, the information gathered through the assessment process helps treatment staff develop treatment plans with clients, following their admission. State statute, as well as federal policy and national accreditation standards, requires that persons with psychiatric disorders receive treatment based on an individualized plan of care. DMHAS policy issued in October 2004 contains further treatment planning requirements that apply to all persons receiving agency services for mental health or substance use disorders.

Under this policy, all services must be provided in accordance with an individualized, multidisciplinary recovery plan developed in collaboration with the person receiving the services. All changes to a plan, and the rationale for the changes, must be documented in a person's treatment record. Under DMHAS policy, the plan must be based on an individual's strengths and a culturally sensitive assessment of the person's needs and resources. According to the department, the primary focus of a recovery plan is the services, structures, and/or supports a person needs to live successfully in the least restrictive environment possible.[30]

[30] Commissioner's Policy Statement No. 33: Individualized Recovery Planning, October 2004.

Chapter III

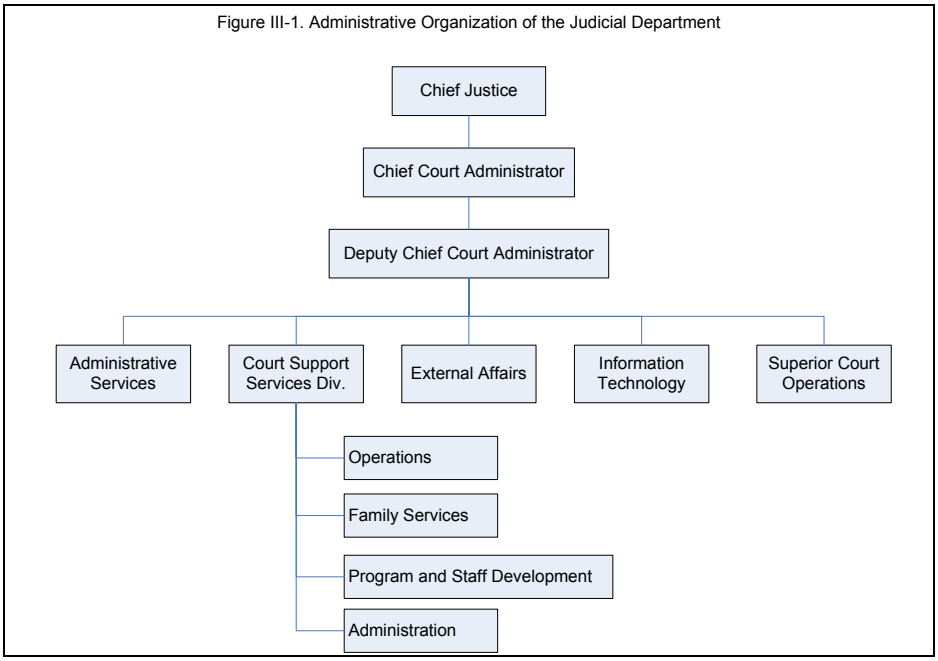
Court Support Services Division

While criminal activity is generated from a variety of factors, a number of research studies have noted a relationship between drug use and crime. It is a crime to use, possess, manufacture, or distribute drugs classified as illegal and the various effects of drug-related behavior are felt daily, from violence that can result from drug use to robberies to get money to buy drugs. Generally, drug users are more likely than nonusers to commit crimes, arrestees frequently are under the influence of a drug at the time they committed their offense, and trafficking in drugs generates violence.

In Connecticut, the Judicial Branch through its Court Support Services Division is responsible for supervising individuals convicted of crimes whose sentences include probation in lieu of or after a prison term. In addition, for persons who are pre-trial, CSSD or a judge can order that person to fulfill certain requirements as a condition of bail, or otherwise divert the defendant. Addressing substance abuse behaviors on the part of these individuals while under the auspices of CSSD is described in this chapter.

As shown in Figure III-1, the Court Support Services Division (CSSD) is one of the five administrative sub-units of the Judicial Branch that report to the chief court administrator, who is the administrative head of Connecticut's court system.

Figure III-1. Administrative Organization of the Judicial Department



The division was established in 1999 as result of a consolidation of six offices.[31] It oversees a range of functions including bail and other pre-trial services, family services, and various probation options for adults and juveniles.

As noted, persons involved with CSSD may be pre-trial (defendants) or sentenced (offenders) and may be referred to programs as ordered by a judge or in some circumstances by probation officers. Its stated mission is "to provide the Judges of the Superior Court and the judicial system with timely and accurate information, quality assessments, and effective services that ensure compliance with court orders and instill positive changes in individuals and families." On average, CSSD supervises nearly 57,000 sentenced offenders on probation and 17,000 pre-trial/diverted defendants on a daily basis for a total of 74,000 persons.

CSSD Profile

The Court Support Services Division is headed by an executive director who oversees a central office and four divisions. The operation of CSSD is also broken down into regional service delivery areas (two regions for juvenile probation and family services, and five for adult services/probation). The four major divisions of CSSD and their sub-units include:

- *Operations* – adult services/probation, juvenile probation, and juvenile detention;
- *Family Services* – family services, center for best practices, and center for research, program analysis, and quality improvement;
- *Program and Staff Development* – training academy and statewide community service; and
- *Administration* – materials management, grants and contracts, human resources, fiscal and administration, and information technology.

The adult services sub-unit within the operations division is further divided into two units: intake, assessment, and referral (IAR); and supervision. The IAR bail staff, formally called IAR specialists, perform a host of pre-trial activities including: collecting criminal and demographic information about defendants; recommending bail; setting conditions of release; and determining eligibility for some pretrial diversionary programs. The IAR probation staff, who are called probation officers, are responsible for offender assessments, pre-sentence investigations, determining eligibility and submitting status reports for some pre-trial diversionary programs, and referral to treatment, as well as monitoring clients to ensure public safety. Probation supervision staff provide supervision to offenders released into the community; promote community protection and victim safety; and make referrals to treatment.

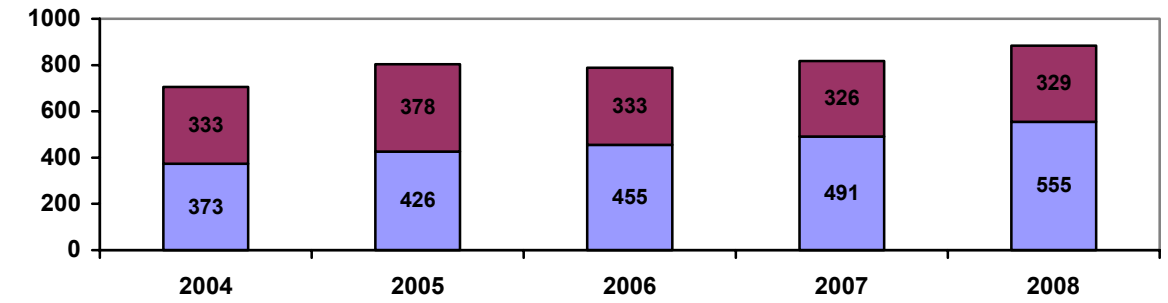
The family services unit provides pre-trial assessment, case management, and supervision services to domestic violence defendants and offenders involved in the criminal court. In civil court, unit staff assist court personnel and clients in the resolution of family and interpersonal conflicts through a program of negotiation, mediation, evaluation, and education.

[31]The consolidated offices were the: Office of the Bail Commissioner; Family Services Division; Juvenile Detention Services; Office of Juvenile Probation; Office of Adult Probation; and Office of Alternative Sanctions.

Employees and caseload. As of June 30, 2008, the division had 1,364 (31 percent) of the Judicial Branch's 4,392 employees. Of the 1,364 employees in CSSD, 64 percent were dedicated to adult services.

As shown in Figure III-2, the total number of adult service employees has increased by about 25 percent since 2004. Probation officers are the largest classification of CSSD employees. The number of adult probation officers has increased over the last five years by 49 percent. Consequently, the Judicial Branch has been able to significantly reduce average adult probation officer caseloads from 160 in 2004 to 91 in 2008. The two criminal justice reform bills passed over the last year authorize a total of 55 additional probation officers to be hired by the end of 2009 (not including the 50 probation officers to be hired this year as a result of the changes to the classification of 16 and 17 year olds). Lower caseloads along with validated assessment tools and evidence-based interventions are correlated with reductions in recidivism.

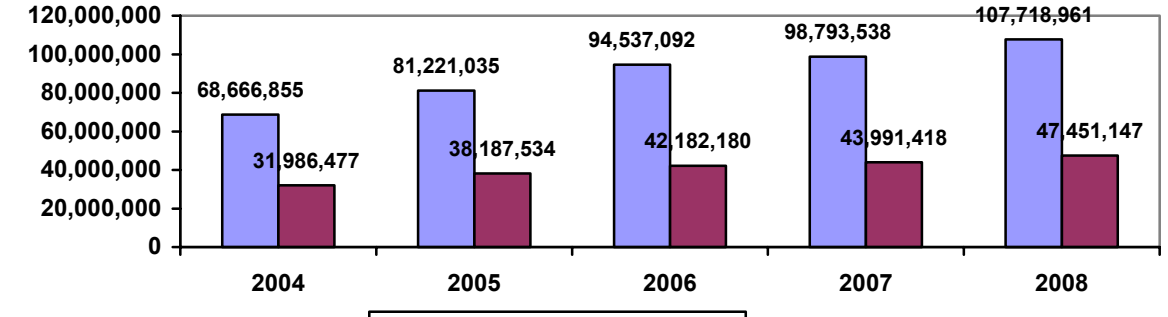
Figure III-2. CSSD Adult Services Personnel, 2004-2008



Source of Data: CSSD

The division's total estimated expenditures in FY 2008 were $194 million, which is approximately 43 percent of the entire Judicial Branch's expenditures. As shown in Figure III-3, about $108 million of total CSSD expenditures (56 percent) was spent on adult services in SFY 2008, an increase of 57 percent since 2004.

Figure III-3. CSSD Expenditures for Adult Services, 2004-2008



Source of Data: CSSD

CSSD contracts with a private, non-profit network to provide most of its client services, except for certain assessments that its staff perform, described below.[32] There are a total of 23 different program models, of which 18 have a substance abuse component for adults. In SFY 2008, the division managed a total of 114 adult services contracts in 149 locations throughout the state. The division spent about $47.5 million through those contracts for adult services.

Substance abuse treatment expenditures. The latest estimate for substance abuse expenditures by CSSD was made in 2005 and includes both adults and those under age 18. The amount spent on substance abuse treatment and non-clinical interventions was $27.1 million or 19 percent of total CSSD expenditures.

Substance abuse risk factors. The precise number of defendants and offenders who are involved in this phase of the criminal justice process and have a substance abuse problem is difficult to determine because not all clients are assessed, as discussed further below. CSSD bail staff ask defendants questions about substance use during the pre-trial intake process. About one-half of the 55,000 pre-trial clients self-identify as having an alcohol or drug problem. In addition, most probation clients are thoroughly assessed as described below. In 2006, 17,522 of CSSD's probation clients were assessed for criminogenic and other risk factors.[33] Of those clients, 9,355 (53 percent) had indicated substance abuse as one of their top problems. Most of these clients with a substance abuse problem were male (82 percent), between the ages of 16-29 (49 percent), and White (58 percent).

Intake, Assessment, and Referral Process

The division uses validated assessment tools from the onset of court intake through the completion of the sentenced period of supervision. The validated assessments used are the Bail Decision Aid, the Domestic Violence Screening Inventory-Revised (DVSI-R), Level of Service Inventory-Revised (LSI-R), and the Adult Substance Use Survey (ASUS-R). These tools are used by CSSD to assist staff in making certain recommendations to the court, such as bail, and for making service referrals after sentencing. The discussion in this chapter, however, is limited to those assessment tools related to substance abuse and determining treatment needs.

Assessment instruments. The division uses two validated assessment instruments to determine a defendant's or offender's risk of recidivating and the need(s) of the clients that lead to or cause crime. They are the Level of Service Inventory-Revised and the Adult Substance Use Survey – Revised. A shorter screening version of the LSI-R (LSI-R-SV) is generally used to determine if a full LSI-R is required. A full LSI-R assessment is mandated for offenders convicted of certain offenses, such as sex crimes, domestic violence, and other serious crimes.

The LSI-R is a validated, objective, quantifiable assessment tool that predicts client risk and service needs. It is a 54-item questionnaire and contains 10 "subscales" about different personal characteristics that are both dynamic (i.e., changeable, such as companions) and static

[32] These include certain assessments known as LSI-R, ASUS-R, and DVSI-R that probation officers and others administer. These assessments are described later in this chapter.

[33] Criminogenic factors are those areas identified by research as predictors of crime and/or related to recidivism.

(non-changeable, such as criminal history). The dynamic factors are what probation and program personnel hope to influence to change an individual's behavior. The subscales are:

- criminal history
- education/employment
- finances
- family/marital
- accommodation
- leisure/recreation
- companions
- alcohol/drug problems
- emotional/personal
- attitude/orientation

Independent studies have shown that the LSI-R has a high level of predictive validity when looking at outcomes of various correctional populations. Its factors have been found to be highly correlated with recidivism and have produced consistent results with subgroups of offenders. The short version (LSI-R-SV) is also a validated assessment tool, and contains eight questions based on a subset of the longer version.

While the LSI-R is a general risk tool, the other instrument, the Adult Substance Use Survey-Revised is a complementary assessment that provides CSSD staff with detailed information regarding client involvement with and disruption caused by alcohol and drugs. The ASUS-R is a 96-question, self-reported survey with 15 subscales that indicates an offender's mood, degree of psychological stress, and emotional well-being. It is completed by the offender under the supervision of CSSD staff. The outcome is used as a guide to help staff discern the level of substance use severity and make treatment determinations.

The Bail Decision Aid is used by CSSD staff in cases where pre-trial release conditions may be appropriate. This assessment was developed in 2004 to guide pre-trial personnel in determining if a bail condition is needed and in matching the client's needs with conditions. The decision aid classifies client needs into three primary areas: personal needs (e.g., substance abuse, unemployment); compliance needs (e.g., living alone); and safety risks (e.g., violent offender). The menu of available conditions (such as drug treatment, call-ins, and electronic monitoring) is similarly organized according to these need areas.

The Domestic Violence Screening Inventory-Revised is administered to all individuals who are arrested for domestic violence. The DVSI-R includes 11 separate items regarding: previous incidents of both non-family and family violence; the presence of weapons; substance abuse and children during the incidents; the defendant's prior participation in family violence intervention; violations of court orders; the defendant's employment status; the presence of verbal or emotional abuse in the relationship; and the frequency and escalation of violence. The DVSI-R also includes a summary risk rating that is completed by the Family Relations Counselors by using their professional judgment to assess the imminent risk of violence towards

the victim and others. The DVSI-R is informed by five sources: the defendant, victim, police report, criminal history review, and the protective order registry (on which all protective orders by judges and police are required to be maintained).

Who is assessed? While all offenders sentenced to probation are assessed, including those with "split sentences" (meaning they are discharged to probation from the Department of Correction after a period of incarceration), there are some offenders or defendants who, based on their charges or diversionary program eligibility, are not assessed. However, an intake form is completed for all CSSD clients and includes four questions related to substance abuse. While the intake form is not an assessment tool, the answers to the intake questions may trigger a full assessment for a low level defendant or offender.[34] The division processes about 25,000 to 30,000 offenders placed on probation on an annual basis and it administers about 15,000 to 20,000 LSI-Rs and ASUS-Rs. In addition, 55,000 pre-trial defendants and 30,000 domestic violence defendants/offenders are interviewed with an intake form annually.

Policy requires that assessments are performed by CSSD staff within 14 days of sentencing, or 90 days prior to discharge from the Department of Correction for split sentence offenders through the probation transition program.[35] Pre-trial defendants may be assessed by contract staff upon entrance to certain programs. It takes about 2.5 hours to administer and score both assessments (LSI-R and ASUS-R).

Case plan. The results of the ASUS-R and LSI-R and any specific court ordered conditions together with collateral information (such as police reports, family feedback, and known criminal history) are used to develop an offender's or defendant's supervision level and case plan to address identified needs.

The results of the two assessments are converted into numerical scores. The LSI-R has 10 subscales or need areas, as listed above. The three areas of highest need are prioritized to develop a case plan and matched with services to address those needs. Similarly, the ASUS-R results in a score that indicates the severity of need. There are four levels of substance abuse services that are provided by CSSD depending on the scores:

1. a zero score indicates substance abuse services may not be needed;
2. low scores (1-2) result in referral to urinalysis monitoring and alcohol or drug education;
3. mid-level scores (3-6) result in a referral to a weekly outpatient program; and
4. high scores (7-10) will be referred to an intensive outpatient clinic or a residential treatment facility.

While the CSSD-administered assessments are meant to provide guidance to staff in making referrals, all treatment providers are required to conduct independent evaluations to confirm the appropriateness of the referral. Because mental health issues often accompany the abuse of drugs and alcohol, both versions of the LIS-R and the ASUS-R have indicators of

[34] These include questions such as: "Are you currently using drugs or alcohol?" and " Were you under the influence of drugs or alcohol at the time of your arrest?" An affirmative answer to any three of the four substance use questions leads to additional questions and possible formal assessment.

[35] The Transition Case Management program is described in Appendix C

mental health needs. Scoring certain items on the ASUS-R mood scale will trigger a formal mental health evaluation.

The CSSD staff also develop a probation supervision level based on the LSI-R, which has to be considered when placing a client into services. A probationer at a higher risk level requires more contact with staff and more intensive and extensive services.

Recently, CSSD has placed more emphasis on collaboration between the offender and staff in developing the case plan. After feedback is given on the assessments, the offender fills out a questionnaire that identifies the issues most important to the offender. CSSD staff will assess and reinforce the offender's motivation and readiness to change. Staff will take into account the offender's degree of motivation in developing the case plan, and which needs to address first. In any event, depending on the classification of the offender, the top two to three highest needs should be addressed during the term of supervision. Re-assessments can be completed throughout the supervision period.

It is important to note that matching the offenders' level of service to the right criminogenic need at the appropriate risk level is crucial to reducing recidivism. Offenders with high needs should be placed in high intensity programs. What is paradoxical is that if low need offenders receive high intensity services, their recidivism rates actually increase.

Motivational interviewing. CSSD staff are trained in motivational interviewing techniques to complete the LSI-R based on self-reported information from an offender. Motivational interviewing techniques include strategies such as asking open-ended questions not easily answered with a single word or phrase, listening reflectively to an offender and repeat what was said back to them, affirming the offender's recognition of a problem and intention to change, and eliciting self motivational statements from the offender that recognize his or her problems and express an intent to change.

Treatment Programs

Treatment programs may be accessed by defendants and offenders at various points in the criminal justice process according to specific eligibility requirements established by law and based on the results of assessments described above. Some programs are only available at a pre-trial stage, while others are available after an offender is convicted as part of an alternative sanction program or probation.

Under most circumstances, pre-trial defendants are also eligible to participate in the programs available to those on probation. In addition, there are specialized community courts and court dockets to which some defendants/offenders may be diverted that focus on specific types of crimes. The programs discussed below are not a comprehensive listing of all CSSD programs, as the focus in this study is on those CSSD programs with a substance abuse treatment component.

Pre-trial programs. Appendix C shows the programs that are usually considered pre-trial diversion programs, with a substance abuse treatment connection. CSSD conducts eligibility determinations, community service oversight, and status reporting; the treatment

components are administered in collaboration with DMHAS. For those participating in these programs on a pre-trial basis (where prosecution has been suspended), charges are nolled and/or dismissed after successful completion.

The drug education program and the community service labor program (CSLP) are intended for people who are charged with possession of drugs and drug paraphernalia. Eligible applicants to the drug education program are referred to DMHAS for placement in a drug education program. Charges are dismissed for those who successfully complete the drug program. (Prior participants in the drug education program or the CSLP are ineligible for the drug education program. Those who have participated in the CSLP twice and those with prior drug possession and sale convictions are ineligible for the CSLP program.)

The pre-trial alcohol education program is intended for people charged with driving while under the influence. Defendants are ineligible if they have been convicted of certain serious motor vehicle crimes. Defendants are referred to DMHAS for evaluation and placement in an educational program or a treatment program.

The fourth "program" is a sentencing option (drug and alcohol treatment in lieu of prosecution or incarceration). Courts may also order defendants who are drug and alcohol dependent into treatment in lieu of prosecution or incarceration. The pre-trial part of this option includes all drug sale and possession crimes. Certain serious motor vehicle crimes or class A, B, and C felonies are not eligible. The court, however, may waive these eligibility rules at its discretion.

Some first-time defendants/offenders may be allowed to use private services and do not use a CSSD network program. These individuals have insurance coverage, and choose to pursue treatment in a more private clinical or doctor-level setting. CSSD receives status letters of compliance from the treatment providers.

There are other programs administered at the pre-trial phase that do not focus solely on substance abuse issues, but do have a component that addresses these issues (e.g., Family Violence Education Program). These programs are described in Appendix E.

Post-conviction programs. Many types of programs with a substance abuse treatment component are available to offenders who have been sentenced and are on probation in lieu of incarceration, or are on probation after a period of incarceration (i.e., split sentence), or not incarcerated because of time served awaiting trial. Several types of services provided by CSSD's network of providers are intended to assist offenders in identifying and changing problem behavior so they may successfully integrate into the community.

Many of the programs offer substance abuse education and treatment as well as other types of interventions, including life skills training, individual and group counseling, vocational counseling, and referral services. A key distinction among the various services is the setting (e.g., more intensive services for a longer duration or less intensive for a shorter duration) and the client profile (e.g., risk level, gender, and ethnicity). As Appendix E shows, the 18 programs with a substance abuse treatment element can be divided into three categories: residential programs, non-residential programs, and special programs (see Tables 1 through 3 in the

appendix). CSSD also collaborates with the DMHAS forensic services division in implementing the two pre-trial education programs (alcohol and drugs), six diversion programs, and two reentry programs, as noted earlier.

Residential. The residential programs include a continuum of inpatient drug treatment services intended to provide offenders with emergency as well as short-, intermediate- and long-term placement. Appendix E describes the various residential programs, target population, and treatment timeframes. Residential programs include halfway houses, transitional housing, medical detoxification, intermediate and long-term intensive treatment (up to 18 months), and facilities for the dually diagnosed with mental illness and drug dependency. The total residential bed network available to CSSD in FY 08 was over 500 beds.

Like the rest of its services, CSSD purchases many of its beds through a bidding process, except for those purchased through a collaborative contracting process with DMHAS and DOC. Currently, the division purchases 287 beds from DMHAS and 18 beds with DOC.

As of July 2008, there were over 480 CSSD clients waiting for residential placement. In 2007, there were over 4,000 referrals to residential services, although only about 1,800 people received them. This means that about 2,200 people who needed them did not receive residential services. If a bed is not available, the client is placed on a wait list and a triage process is used by staff to address client needs, which may include non-contracted substance abuse treatment or transitional housing with Adult Incarceration Center services (see description of AIC below).

Non-residential. Most defendants/offenders involved with the criminal justice system have multiple service needs and the adult service programs provide a range of community-based non-residential services. The non-residential programs are among the most heavily used. The average wait time for outpatient services is about two to six weeks across the state. The wait times are significant because the large majority of those waiting are housed at the Department of Correction, incurring costs of about $121 per day.[36] The daily cost for a CSSD bed ranges from $65-$104.

The Adult Behavioral Health Services programs provide substance abuse evaluations, weekly substance abuse outpatient treatment, intensive outpatient treatment, group anger management, and mental health evaluation and treatment. These services may be accessed at 37 locations throughout the state, and in FY 08 about 10,400 clients were served. The average wait time for outpatient services is two to six weeks across the state.

Alternative Incarceration Centers (AICs) provide monitoring, supervision, and programming during the day and evening in a structured center-based setting. They offer case management services, substance use assessments, and group interventions (including substance abuse treatment), and also focus on employment skills and job development. Some AICs have

[36] Based on the Office of Fiscal Analysis estimate - the annual cost to incarcerate an inmate in Connecticut in FY 06 was $44,165. See also February 13, 2008, OLR Memo, *Cost of Incarceration and Cost of a Career Criminal*- 2008-R-0099.

transitional housing associated with them, but services are delivered at the AIC. There are 17 centers statewide that served about 8,700 clients in FY 08.[37]

The Adult Risk Reduction Centers (ARRC) are intended for high risk and high need probation clients. Offenders report regularly for treatment and typically have multiple needs. The ARRC program is intended to provide targeted interventions that focus on anger management, substance abuse treatment, motivational enhancement training, cognitive restructuring, and reasoning and rehabilitation. About 134 offenders were served in FY 08.

The Drug Intervention Program (DIP) replaced Connecticut's drug courts. There were five drug courts in Connecticut that were terminated in 2001 because of high costs. The DIP is available in New Haven, Bridgeport, and Danielson. Eligibility requirements for DIP include that the offender be drug dependent and have a non-violent criminal history. Persons eligible for DIP may be identified at any point in the court process. Referrals may be made by judges, defense counsel, state's attorneys, or CSSD staff. Defendants are required to plead guilty to any charges and sentencing is deferred pending completion of the program.

The court uses a more intensive team approach within the DIP (including attorneys, treatment personnel, and court personnel), and the offenders are required to report to the court on at least on a monthly basis. A course of treatment is developed with private nonprofit treatment agencies and CSSD providers, which may include an inpatient stay. The program lasts 12 to 15 months depending on progress in treatment. In FY 08, 167 people participated in this program.

Special services. As shown in Appendix E, there are a number of CSSD programs that target offenders with special service needs or who have been traditionally underserved. This includes programs aimed at domestic violence offenders as well as female and Latino offenders. Males involved in family violence offenses may participate in two programs offered statewide. The 26-week EXPLORE and more intensive 52-week EVOLVE domestic violence programs focus on education and behavior change to encourage positive interpersonal relationships and to aid in conflict resolution. Six of the sessions in the EXPLORE program and 12 sessions of EVOLVE focus on the role of substance abuse in violent behavior. Two other domestic violence programs, the Bridgeport Domestic Violence Intervention Services and the Family Violence Education Program, have either a substance abuse evaluation and treatment or education component.

Female offenders often have dependent children, a history of substance abuse, or have been victims of abuse or sexual assault. CSSD has two programs geared to the unique service needs of female offenders. Gender Specific Programming for Females is a non-residential program for women that provides gender responsive assessment and clinical services, while the Women and Children program is a residential (4-12 months) treatment and rehabilitation program for women that allows women to be housed with their children.

There is also a program tailored to Hispanic clients located in New Haven, called Latino Youth Offender Services. The bilingual/bi-cultural program provides intensive case

[37] The table in Appendix E shows 20 AICs; technically there are 17 AICs and three other locations that are AIC transitional housing programs.

management, counseling, education services, and substance abuse treatment for Latino male offenders between 16 and 23 years of age.

Evidence-based programming. Most of the programs offered by CSSD can be classified as research-based programming, with a few exceptions. The domestic violence programs meet the higher standard of being evidence-based (i.e., Evolve and Explore), while the Halfway House model is neither; this program addresses basic client needs of housing and supervision. Research-based programming means that there is research to support the effectiveness of the practices, though it may not be specific to the treatment organization's population, age group, or gender; their primary substances of abuse; and even the geographic location.

Chapter IV

Department of Correction

Substance abuse is a significant problem within the adult correctional population nationwide. In the 2004 Survey of Inmates in State and Federal Correctional Facilities conducted by the U.S. Bureau of Justice Statistics, 32 percent of state prisoners, and 26 percent of federal prisoners, said they had committed their current offense while under the influence of drugs. Among state prisoners surveyed, drug offenders and property offenders reported the highest incidence of drug use at the time of the offense (44 and 39 percent, respectively). In Connecticut, the sale of hallucinogen/narcotic substances, and possession of narcotics, are among the top three offenses of the incarcerated population.

Numerous studies have noted that addressing an offender's substance use and addiction is an essential component of successful reentry into society. Treatment for alcohol and drug abuse increases the likelihood that former inmates will find and keep jobs, secure housing, and forge positive intimate and familial relationships after their release. In addition, research shows that in-prison substance abuse treatment, when linked with post-release continuity of treatment, can reduce post-release drug use and enhance positive outcomes.

This chapter provides an overview of the substance abuse treatment role and responsibilities of the Connecticut Department of Correction. As the state correctional agency, DOC is responsible for confining pre-trial defendants not released on bail and offenders sentenced to incarceration. The department provides medical and rehabilitative services to incarcerated offenders, and supervises and provides services to certain offenders who have been released into the community. The department's mission is to "protect the public, protect staff, and ensure a secure, safe, and humane supervision of offenders with opportunities that support successful community reintegration."

On average, the department annually confines about 19,500 individuals in 18 correctional facilities (about 20 percent of which are pre-trial), and supervises another 4,300 inmates in various community programs for a total supervised population of approximately 24,000 offenders. A total of 34,800 people were admitted to DOC in the last year and 20,300 were released from DOC custody (12,100 at the end of their sentences) or to DOC community supervision (8,200).[38] Another 14,500 are released for various reasons, including release on bail, the case not pursued, transfer to probation, or the person was sentenced to time served.

Obtaining appropriate medical care, treatment, and skills-based training are important elements of an inmate's successful reintegration into the community. As DOC notes, about 95 percent of all inmates are eventually released from custody. Given that fact, the department has increasingly emphasized and strengthened its focus on each inmate's need to be prepared to return to and integrate back into the community. Re-entry planning begins at the beginning of incarceration at a DOC facility. As each inmate nears the end of his or her incarceration, DOC

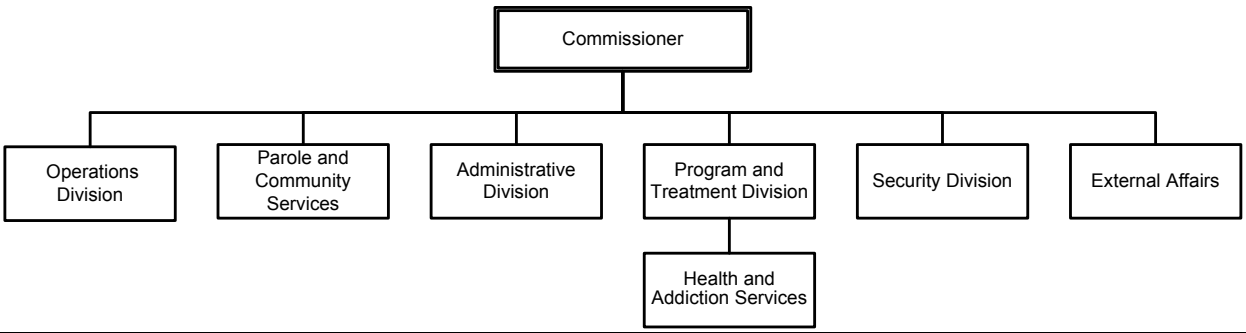
[38] Current Correctional Population Indicators Monthly Report, Office of Policy and Management, August 2008. Average refers to the period of August 1, 2007 through July 31, 2008.

provides various transitional and support services to prepare for discharge into the community. Substance abuse programs are a critical component of this preparation for many offenders.

The department maintains a formal substance abuse screening and assessment process and provides a continuum of substance abuse treatment services. About 12,000 incarcerated pre-trial and sentenced inmates (65 percent) are in need of addiction treatment services. About 5,500 offenders were admitted to one of the department's formal "Tier" programs (46 percent of those in need) and about 2,700 inmates completed one of the programs. Over 2,400 inmates were on a wait list for one of the department's treatment programs at the end of SFY 07.[39] Within the incarcerated population, nearly $7.1 million was spent on treatment in SFY 07.

For offenders in the community on parole, the department spent $6.8 million on substance abuse treatment in 2007. About 8,200 offenders were released into the community on parole in the last year and approximately 5,600 (68 percent) offenders were in need of addiction treatment. Information on the number of parolees that did not receive treatment because they completed their sentences before the end of treatment is not readily available, though the department reports that there are no wait lists for substance abuse services under the parole division. About 12,000 offenders reach the end of their sentences at DOC (without transfer to parole), and it is not known how many do not receive any treatment.

Figure IV-1. Department of Correction – Major Divisions



Organization. As shown above in Figure IV-1, the Department of Correction is composed of six major divisions. Two divisions have a role in providing or overseeing substance abuse treatment for offenders. The Programs and Treatment Division provides substance abuse treatment through the Health and Addiction Services Unit to incarcerated offenders and those released through transitional supervision and for certain offenders on parole. (Transitional Supervision is a statutorily authorized form of early release that is under the discretion of the warden of each correctional facility).

[39] Not everyone who is eligible for addiction treatment signs up for treatment. It is not a requirement.

In addition, the Parole and Community Services Division is responsible for supervising offenders who have been released into the community prior to the end of their sentence, including those released on parole under the discretionary authority of the Board of Pardons and Parole and those released by DOC under Transitional Supervision. Each unit will be discussed separately below.

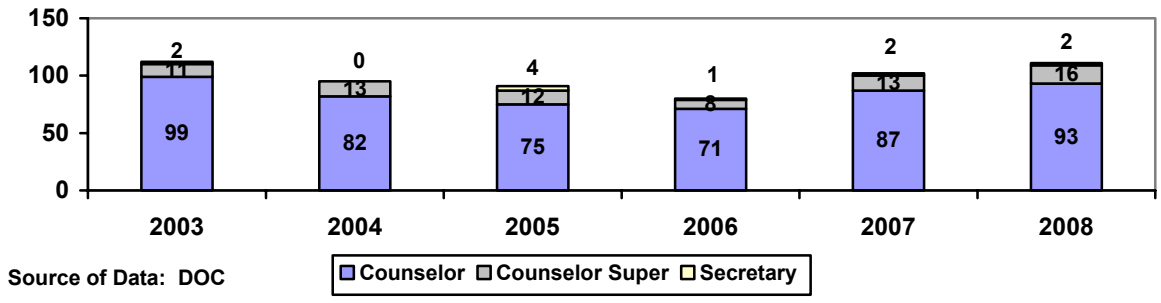
Profile: DOC Health and Addiction Services Unit

A director of the Health and Addiction Services Unit, who reports to the head of the DOC Programs and Treatment Division, is responsible for overseeing the provision of a comprehensive health care system for the offender population that includes medical, mental health, dental, substance abuse, and ancillary services. Except for substance abuse treatment, all other medical care is carried out through a partnership with the University of Connecticut Health Center.

Within the Health and Addiction Services Unit there is an Addiction Services Unit (ASU) headed by a deputy warden. The stated mission of ASU is to "provide treatment for inmates with substance abuse problems, provide for continuity of care, and support the Department of Correction mission of public safety through substance abuse treatment, staff training, and program evaluation consistent with established best practices."

ASU Staffing. As shown in Figure IV-2, the ASU is currently staffed by 93 substance abuse counselors, 16 counselor supervisors (not including the deputy warden), and two secretaries, for a total of 111 staff. This is one less staff position than six years ago; however it is a 39 percent increase since 2006, when ASU was reduced to 80 staff. All substance abuse counseling staff maintain professional certification or licensure as Alcohol and Drug Counselors through the Department of Public Health. The DOC is the only state agency that is required to maintain certification per P.A. 02-75.

Figure IV-2. DOC Addiction Services Staffing, 2003-2008



Source of Data: DOC

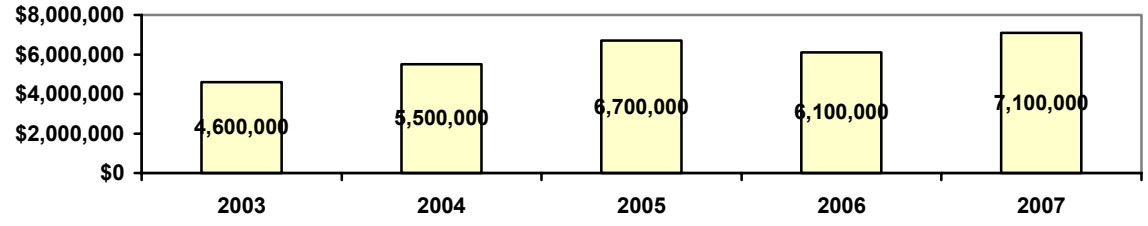
The ASU central office contains the deputy warden and three counselor supervisors who perform various operational, administrative, and clinical duties. As outlined in Appendix F, the Addiction Services Unit operates programs in 17 of the department's 18 correctional facilities. However, some high security sections within multi-security level facilities may not have ASU programming. Due to the long-term nature of the confinements at the Northern Correctional Institution in Somers, that facility has no addiction services programming. If any Northern

inmates are to be released into the community, they are generally transferred to other facilities with programming.

Thirteen of the sixteen counselor supervisors oversee counselors in the various facilities or in regional parole offices. Three of the 13 counselor supervisors are assigned to supervise multiple sites. Each facility with programming has between two and 11 counselors. Addiction services are also provided to inmates who are released into the community before the end of their sentences through parole or Transitional Supervision. These services are provided at four of the department's five Parole and Community Services Offices.

Expenditures. As shown in Figure IV-3, expenditures for substance abuse treatment provided through ASU have increased by about 54 percent since 2003 from $4.6 million to $7.1 million. This increase is greater than the 19 percent increase for total DOC expenditures over the same time period ($535 million increasing to $636 million). Substance abuse treatment provided through ASU represents just over one percent (1.12 percent) of the entire DOC budget.

Figure IV-3. ASU Expenditures on S/A Treatment, 2003-2007



Source of Data: DOC

ASU Institutional Intake, Assessment, and Treatment Process

The intake and assessment process for DOC inmates begins at pre-sentencing and during direct admission to facilities. The Department of Correction houses accused (awaiting trial/disposition), unsentenced, and sentenced populations. Incarcerated pre-trial defendants may participate in many of the services available to the sentenced population but formal release planning is not performed due to the transitory nature of this population.

Health services personnel meet with inmates and perform initial screens for acute mental and medical health needs when admitted to DOC. Offenders with special needs are placed in facilities designed to address specific issues (e.g., serious medical and mental health issues).

Generally, newly admitted inmates receive an initial need and risk assessment to determine their security classification. Offenders serving sentences greater than two years are transferred to the MacDougall Walker and York Correctional Institutions for orientation and assessment (York is the sole women's facility in the state). Within 10 days, a series of assessments are performed that includes an extensive medical and mental health examination, a substance abuse evaluation, educational and vocational assessments, a sex offender treatment needs review, and a security risk management review.

Offender Accountability Plan. The results of the assessments form the basis of each inmate's Offender Accountability Plan (OAP), which outlines the treatment and programming needs for the duration of an inmate's incarceration. The OAP requirements were implemented in January 2006 for each newly admitted inmate. The OAP is developed in collaboration with the inmate. Those offenders who are serving two years or less are classified and assessed at pre-trial facilities (Hartford, New Haven, Bridgeport, and Corrigan) and transferred to another facility where the OAP is developed and implemented.

The purpose of the OAP is to address the specific areas that need to be modified so that the inmate may successfully reintegrate into the community. The plan also includes behavioral expectations as well as spiritual, family, and community support components. It is through the OAP that the department begins planning for and assisting the inmate's ultimate discharge back into the community. After development of the OAP, the inmate is transferred to an institution commensurate with his/her assigned security level. The OAP is reviewed and modified on a regular basis through the term of incarceration to assess progress and reinforce achievement of stated goals.

During the orientation phase of incarceration, a parole officer from the Board of Pardons and Parole meets with each offender to outline the eligibility criteria and expectations for earliest possible discretionary release. While treatment and other activities needed to gain skills for reintegration cannot be legally required of inmates, the parole board emphasizes the benefits of doing so.

Substance abuse assessment. The Addiction Services Unit uses two substance use assessment tools for adults. They are the Texas Christian University Drug Screen II (TCUDS) and the Addiction Severity Index (ASI).[40]

The TCUDS is a screening tool that allows correction staff to quickly identify individuals who report heavy drug use or dependency and might be eligible for treatment. It is a standardized, evidence-based 15-item assessment. The measures in the tool represent diagnostic criteria for substance abuse and dependence as specified in the Diagnostic and Statistics Manual (DSM-IV-TR). There are two parts to the TCUDS – one part of the scale includes questions related to drug and alcohol use problems and the second part addresses the frequency of use and readiness for treatment. Several studies have demonstrated its reliability and validity in criminal justice settings.

The TCUDS is used in the four DOC pre-trial facilities. The TCUDS is quicker than the ASI to administer on a larger number of individuals. It takes about 15 to 25 minutes to complete and DOC administers it to incoming pre-trial defendants and offenders in a group setting. The self-reported responses are scored by addiction services staff. In 2007, ASU staff performed 13,494 TCUDS on adults.

For the sentenced population (entering through two DOC facilities), ASU staff use the Addiction Services Index. The ASI is a semi-structured interview instrument that addresses both alcohol and drug use in the preceding 30 days and over one's lifetime. It is designed as a

[40] A teen version of the ASI is used for those under 18 called the Teen Addiction Severity Index.

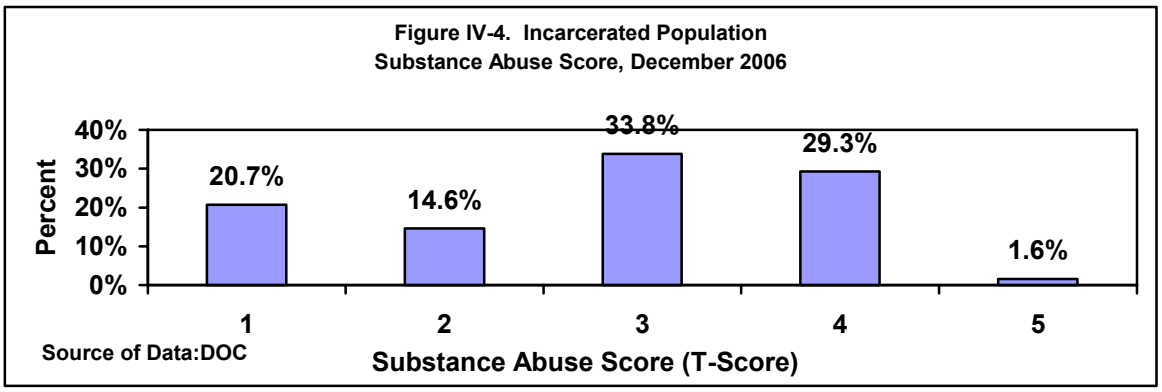
comprehensive assessment tool with over 200 questions that cover seven potential problem areas. The department, though, only uses the 35 questions related to substance abuse.

The ASI is administered by an ASU staff person. The average time to administer the ASI has not been calculated. Program administrators note that the questionnaire with its open-ended questions allows the clinician to have a more in-depth conversation with the offender as the interview progresses. In part, the interview process begins the therapeutic process of engaging the offender about his or her substance use and dependency and identifies what can be done to address the offender's needs.

While the ASI is widely used on prison populations throughout the U.S., systematic tests of the reliability and validity of the ASI in populations of substance abusers within the criminal justice system have not been done. DOC asserts that research does support the use of the ASI across a spectrum of substance abuse treatment environments and populations.

In 2007, ASU staff performed 6,033 ASIs on adults, which, when combined with the TCUDs noted above, means addiction services staff performed about 20,000 substance abuse evaluations on adults that year.

Treatment. The ASI scores are calculated and converted into a severity scale ranging from one to five, which are called substance abuse treatment need scores, or T-Scores. The distribution of T-Scores for the DOC incarcerated population at the end of 2006 is presented in Figure IV-4. While nearly 80 percent of DOC inmates come into the system having some level of substance abuse history (T-Score of 2 or more), about 65 percent have a score that requires an intervention with formal treatment programming (T-Score of 3 or more). For FY 06, this equated to about 12,000 inmates in need of addiction services.



How the T-Scores relate to the level of treatment required is summarized in Table IV-1. The department's substance abuse treatment services are available at four levels (i.e., Tiers I through IV). An individual's service level depends both on the amount and intensity of treatment required based on individual needs, and the point in time at which intervention is determined to be the most effective. (See Table IV-2 for a description of the Tiers).

Table IV-1. DOC Substance Abuse Treatment Need Scores and Response*

Score	Assessment	Response

T-1	Individual does not appear to have a substance abuse problem.	These individuals do not require any substance abuse intervention.
T-2	Individual has a slight substance abuse history and would benefit from brief substance abuse intervention.	The appropriate level of intervention is voluntary participation in recovery support services.
T-3	Individual receiving this rating has a moderate substance abuse problem.	The appropriate level of intervention is Tier III where available, or Tier II programming and community-based aftercare services. If the inmate has not completed Tier II or Tier III during this period of incarceration, community-based outpatient substance abuse treatment is recommended.
T-4	Individual receiving this rating indicates a serious substance abuse problem and requires residential or intensive outpatient treatment.	The appropriate level of intervention is completion of a Tier IV (Therapeutic Community) program where available, community residential substance abuse treatment and community based-aftercare services. If the inmate has completed Tier III or Tier II during this period of incarceration, community-based outpatient services are recommended.
T-5	Individual has an extremely serious substance abuse problem and requires a high-level of intensive treatment of extended duration, such as DOC residential treatment. Individual has a very high probability of relapse into active substance abuse.	The appropriate level of intervention is completion of a Tier IV (Therapeutic Community) program where available, or long-term community residential substance abuse treatment. If the inmate has completed Tier III or Tier II during this period of incarceration, reevaluation by Addiction Services is recommended for community-based outpatient services.
* There is a less-intense Tier I program designed for inmates with a T-Score of 3 or above who are within 90 days of their release. Source of data: DOC		

Table IV-2 describes each of the four tiers of treatment and shows the number of facilities where they are offered. The table also shows the number of inmates who completed the programs, and compares that to the number discharged from the programs. The far right column also shows the number of inmates on the wait list at the end of FY 2007. (See Appendix F for substance abuse treatment offerings by DOC facility.)

Overall, in FY 2007, a total of 2,700 inmates completed one of the department's tier programs, while another 2,400 were on the wait list for a program. Over the same time period, the department received more than 26,000 "Inmate Program Requests."

Table IV-2. DOC Addiction Services Tier Programs				
Programs	**Description of Program**	**No. of Facilities Offered**	**2007 No. Discharged* /Completing Program** (% Complete)**	**No. on Waitlist At End of FY 2007***
Tier 1	Pre-release substance abuse education program -- Nine sessions based on the evidence-based "Beat the Streets" curriculum. Program is intended for inmates who are within 90 days of release to the community. DOC notes that that model is not evidence-based but has "longitudinal reliability within the correctional environment."	8	n/a/1,355	397
Tier 2	Intensive outpatient substance abuse treatment -- Uses an evidence-based curriculum ("Living in the Balance") provided three times per week for 10 weeks in a non-residential setting. The model is evidence-based and validated in correctional facilities.	10	1,385 / 1,037 (75%)	1,846
Tier 3	A four-month residential substance abuse treatment designed to provide recovery and relapse prevention skills in preparation for reentry in the community -- The program is based on a modified therapeutic community model. Participants are housed separately from the general population. This is an evidence-based model validated in correctional facilities.	2	126 / 61 (48%)	128
Tier 4	Longer-term residential treatment (6 months) based on a Therapeutic Community Model with full-time programming -- Participants are all housed together, separate from the general population and are expected to attend school or hold a job while in the program. This is an evidence-based model validated in correctional facilities.	4	702 / 247 (35%)	51
*Discharged refers to individuals who have left the program and includes completers and non-completers **Includes Manson Youth Institution, a facility for young offenders between the ages of 14 and 21. It offers Tiers 1, 2 and 4. Source of Data: DOC				

As the table indicates, less intensive programs (Tiers 1 and 2) are offered at more facilities than the more intensive Tier III and IV programs, which combined are only offered at six facilities. In general, the tier programs require a T-Score of T-3 or higher. For the most part, eligible inmates also must have a certain mental health rating to participate; they cannot have a severe mental health disorder (see following discussion of co-occurring conditions). Finally, inmates must not have any disciplinary issues and have enough time on their sentences to

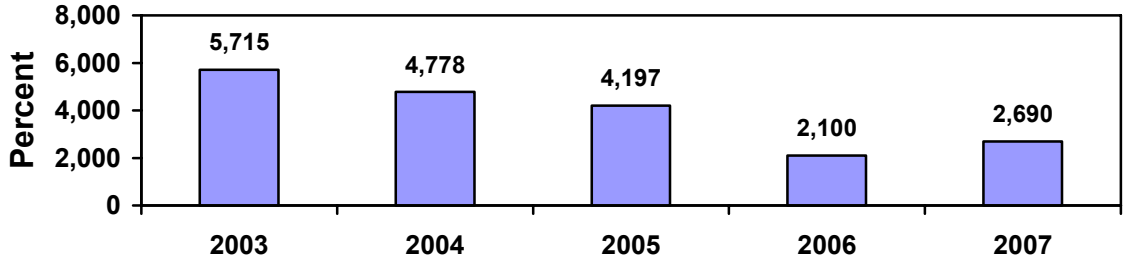
complete the indicated program. Priority is given to those inmates with less than 3 years to serve on their sentences.

The Tier 1 program had the highest number of participants, but it also has the shortest number of sessions and is limited in its objectives. Tier 1 admits all offenders with a treatment need (T-Score of 3 or higher) and are within 90 days of release.

The Tier 2 program had the highest percentage completion rate (75 percent), while the residential programs, Tier 3 and Tier 4, had the lowest completion rates at 48 percent and 35 percent respectively. This is in part due to the length and rigor of the program requirements in the residential programs.

Figure IV-5 shows the number of participants completing the Tier programs has declined by about 53 percent over the last five years. The biggest reductions were in the Tier 3 (down 69 percent) and Tier 1 programs (down 68 percent). DOC administrators have cited a number of reasons for this decline including changes made in the eligibility requirements for Tier 1 (pre-2004, anyone could attend) and changes to the Tier 3 program design and the number of sites offered (seven sites down to two).

Figure IV-5. Number of Inmates Completing Tier Programs, 2003-2007



Source of Data: DOC

In addition, the overall completion rate (program completions compared to program discharges) over the last five years for Tiers 2 through 4 has declined from 65 percent to 61 percent. DOC administrators cite several reasons for this decline including a reduction in counselor staffing through 2006, a focus on providing more services to offenders closer to discharge (resulting in more discharges prior to completion), and a decrease in the amount of space available for non-residential programming.

Client ratios and caseloads. Each program has optimal client to staff ratios that range from 25 to one for Tier 1 to 10 to one for Tier 4. The size of caseloads among counselors varies depending on the Tier level of treatment and other programming for which they are responsible. A clinician who is responsible for performing assessments and running Tier 1 programs may have a caseload of 75 clients. A clinician running a Tier 2 program with the responsibility of overseeing an aftercare program may have a caseload of 40 clients. Tier 3 and Tier 4 programs have a 10 to 1 caseload ratio, but within each of these therapeutic programs the counselors are responsible for each resident, which could treat as many as 75 clients.

Co-occurring condition. As of July 1, 2008, about 19 percent of the offenders incarcerated in a DOC facility had a mental health issue that required treatment. About another 13 percent of inmates have both a mental health issue and a substance abuse issue (co-occurring condition). Those with the most serious mental health issues are housed and treated at Garner Correctional Institution. Historically, those offenders with more severe mental health disorders would not be eligible for addiction services unit programs. In FY 08, DOC implemented a co-occurring disorders program at Garner. The department is expanding the program to two more facilities in SFY 2009.

Facility aftercare. Aftercare is an important part of the recovery process. Aftercare refers to continuing care services offered after discharge from a treatment program. It is intended to prevent relapse by encouraging the development of social networks and activities to address emotional needs of recovering alcoholics and substance abusers. Aftercare is available in 12 DOC facilities and is offered to anyone who has competed Tier 2 or higher programs.

Aftercare sessions are co-facilitated by addiction services staff and inmate participants, consisting of three open group sessions per week for a total of 30 sessions over 10 weeks. In addition, 18 DOC facilities offer Alcoholics Anonymous (AA) and 17 offer Narcotics Anonymous (NA). Both programs help to support treatment efforts by reinforcing recovery attitudes and practices. In 2007, there were about 1,400 AA meetings and 1,100 NA meetings conducted in DOC facilities. In addition, 14 facilities offer other 12-step based recovery support groups.

Other institutional programs. The ASU is also involved in other substance abuse treatment and treatment-related programs offered within DOC facilities aside from the main Tier programs. These include the following:

- *DUI Awareness* – This is a program for offenders who were convicted of driving while under the influence (DUI) of alcohol or drugs and other related offenses. The program consists of a 14-session psycho-educational group using the Hazelton Institute's "Who's Driving" curriculum.

- *Jail Re-interview Project* - The Jail Re-interview Project enables CSSD's intake, assessment, and referral staff to reassess pre-trial defendants held on bond for the development of a supervised, community-based treatment program instead of incarceration prior to trial. The ASU staff are a referral source for this project.

- *Technical Violations Program* – The program provides substance abuse treatment to offenders remanded into custody for non-compliance with the stipulations and/or conditions of their release to the community. The program uses the evidenced-based "Matrix Program" (15 sessions) and "The Relapse Prevention Workbook for Criminal Offenders" (10 sessions) to meet the needs of this defined offender population. The program is designed to return the offender to the community within 60 days of being remanded.

- *Drug court recommendations* - ASU staff refer possible candidates to the CSSD's Drug Intervention Program, as described in the previous section.

- *Bridging the Gap* – This is a service provided by ASU staff to get information about the nearest Alcoholics Anonymous meeting location along with the name of a contact person for inmates about to be released. The AA member will contact the inmate upon release and provide transportation to the meeting.

- *Peer Mentors* – Peer mentors are graduates of the Tier programs who assist ASU staff in the presentation of Tier programs to new groups along with 12-step Fellowship groups. The primary purpose of peer mentors is to model a recovery lifestyle for other program participants. ASU staff provide weekly training to peer mentors.

- *Non-Tier substance abuse-related groups* – ASU staff conducted 352 non-Tier substance abuse-related group counseling sessions in SFY 07. These included groups on anger management, fatherhood, and relationships. These groups are intended for offenders eligible for DOC services who have already completed and/or are waiting to be added to a program list.

Community Addiction Services Programs. The Community Addiction Services Programs (CAS) provide substance abuse treatment for offenders placed on Transitional Supervision, the community release program under the jurisdiction of DOC for inmates with a sentence of two years of less. (This is distinct from parole, discussed below). Other eligibility requirements include a substance abuse treatment need score of T-2 or higher, a certain mental health status, and a minimum of 10 weeks remaining on the inmate's sentence.

These programs are staffed by five ASU counselors and overseen by a counselor supervisor. The staff is located in four of the Parole and Community Services offices: Bridgeport, Hartford, New Haven, and Waterbury.

The goal of these programs is to provide continuity of care in the areas of substance abuse treatment and reintegration into the community. The programs emphasize a balance of substance abuse treatment, encourage attendance in 12-step fellowship support meeting in the community, and maintaining a focus on recovery and reintegration. Generally, the treatment services include psycho-educational recovery groups, individual counseling, and community resource referrals. The optimal client to counselor ratio in these programs is 15-20 to one.

Table IV-3 provides a description of the CAS programs, the number of offenders completing the programs compared to the number of discharges, and the number of counseling sessions for individuals and groups provided by CAS staff. The completion rate for the CAS programs runs from 45 percent for the Women's Recovery Group to 15 percent for the Relapse Prevention Program. The Matrix Program, the Relapse Prevention Workbook for Criminal Offenders, and the Helping Women Recover Program are evidence-based programs

recommended by the federal Center for Substance Abuse Treatment (CSAT) for the correctional population.

Table IV-3. DOC Community Addiction Services Programs Primarily for Prospective Transitional Supervision Offenders: 2007		
Programs	**Description of Program**	**No. Discharged /Completing Program (% Complete)**
Primary Substance Abuse Treatment Program – Early and Continuing Recovery Skills	The *Early Recovery Skills Group* is an eight-session intensive outpatient treatment module designed to meet the needs of those newly released to community supervision, who have 60 to 90 days remaining on their sentences. May also be used as an introduction to continuing recovery skills group. The *Continuing Recovery Skills Group* is a 16-session intensive evidence-based outpatient treatment module for those released from incarceration either on parole or Transitional Supervision status and have at least 120 days remaining on their assigned release program. Both programs are modeled on the Matrix Model developed by the Matrix Institute.	838 / 355 (42%)
Relapse Prevention Program	A 10-session evidence-based program designed to help the addicted inmate to: 1) identify relapse triggers; and 2) develop a situation-specific plan to avoid a relapse or reenter a recovery-focused lifestyle. Based on a CENAPS relapse prevention model of treatment, this program was designed to be the initial intervention for offenders who relapsed into active substance use while on Transitional Supervision or parole.	149 / 23 (15%)
Women's Recovery Group	A 10-session gender-specific program designed to integrate the theory of addiction, the theory of women's psychological development, and theory of trauma into a client interactive program. This program is based on Stephanie Covington's "Helping Women Recover" program.	87 / 39 (45%)
		No. Sessions
Individual Counseling for Males	Individual counseling sessions are used for male offenders who do not have enough time prior to discharge to complete a structured treatment program. Individual counseling sessions are required for offenders admitted to DOC structured programming.	430
Individual Counseling for Females	Similar to the above, individual counseling sessions are used for female offenders who do not have enough time to complete a structured treatment program prior to discharge. Individual counseling sessions are required for offenders admitted to DOC structured programming.	235
Total Group Counseling Sessions	Total number of group sessions for CAS programs described above.	1,425
Source of Data: DOC		

Discharge planning. Inmates discharge from DOC facilities go either directly to the community with no further supervision (because they reached the end of their sentences),

through parole, Transitional Supervision, or to probation.[41] The process for inmates who are discharged to parole or transitional supervision is described below. All inmates discharged from DOC facilities at the end of their sentences develop a discharge plan at a minimum of 45 days prior to release. Transition counselors assist the inmate with making arrangements for the transition by addressing matters such as housing, clothing, transportation, medical and mental health treatment, identification, and after care programs.

While this planning is not mandatory, inmates are strongly encouraged to participate. The program consists of a workbook and a video presentation. The video is a series of presentations from private and public service agencies that highlight what each agency does and how an inmate can access its services. Job centers and information kiosks listing various statewide resources are also available at certain institutions to allow inmates to obtain information. The "Bridging the Gap" program, described above, is also available to inmates at time of discharge. Planning for a comprehensive statewide re-entry strategy is underway through the Office of Policy and Management.

Profile: Parole and Community Services Division

The DOC Parole and Community Services Division (parole division) is responsible for supervising and providing support services to all offenders released on parole by the Board of Pardons and Paroles, or to transitional supervision by the Department of Correction. The mission of this division is to "enhance public safety by providing offenders opportunities to successfully reintegrate into the community and be productive, accountable members of society." Ultimately, the goal of the division is to reduce recidivism by providing services and supervision that increase the probability of each offender's successful reintegration.

Organization. The parole division is the result of a consolidation of the community supervision and enforcement functions of the Department of Correction and the former Board of Parole, which occurred in the fall of 2004 at the direction of the General Assembly. As noted above in Figure IV-1, the Director of Parole and Community Services reports directly to the commissioner of correction and is responsible for the division's administration, operations, and planning.

The parole division has a central office in Hartford and five district offices in Bridgeport, Hartford, New Haven, Norwich, and Waterbury. Parole managers and officers in each district oversee the progress of offenders and monitor their adherence to release conditions. The level of offender supervision ranges from very intensive (twice weekly reporting plus electronic monitoring) to minimal supervision (once monthly reporting). Current staffing for the division totals 157 and includes 124 parole officers and managers, 26 field support staff, and seven members of the director's office.

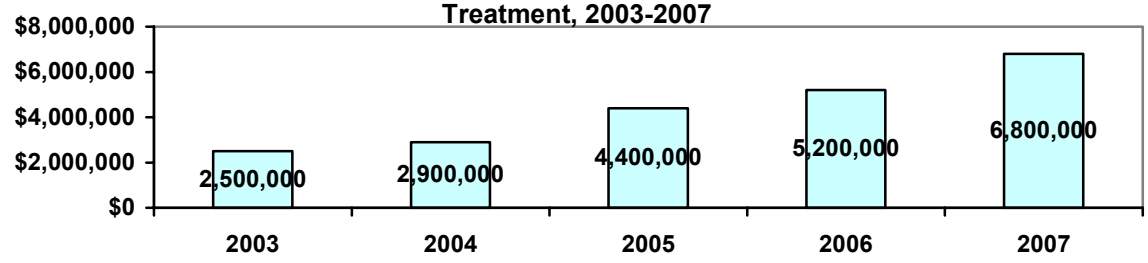
The central office also contains a number of specialized units, including: standards and compliance, central intake, residential services, special management (for sex offenders), mental health, fugitive investigations, and strategic planning and research. These specialized units work

[41] Parole is a form of early release available to certain offenders serving sentences greater than two years. By statute, offenders convicted of non-violent crimes are eligible for parole after serving 50 percent of their sentences. In most cases, offenders convicted of certain violent crimes must serve 85 percent of their sentences.

with the district offices to enhance offender accountability and public safety. For example, the mental health unit, established in 2007, contains five officers and a parole manager who have smaller specialized caseloads that consist of offenders who have histories or current diagnoses of significant mental health disorders. The officers in this unit receive 40 hours of specialized training provided by DMHAS and DOC mental health treatment specialists.

Expenditures for treatment. As shown in Figure IV-7, expenditures for substance abuse treatment provided through the parole division have increased by about 172 percent since SFY 2003 from $2.5 million to $6.8 million in SFY 2007. This increase is greater than the 19 percent increase for total DOC expenditures over the same time period ($535 million to $636 million). Substance abuse treatment provided through parole represents just over one percent (1.1 percent) of the entire DOC budget. The combined expenditures for the addiction services unit and the parole division for substance abuse treatment in SFY 2007 was nearly $14 million or about 2.2 percent of the total DOC expenditures.

Figure IV-7. Parole and Community Services Expenditures on S/A Treatment, 2003-2007

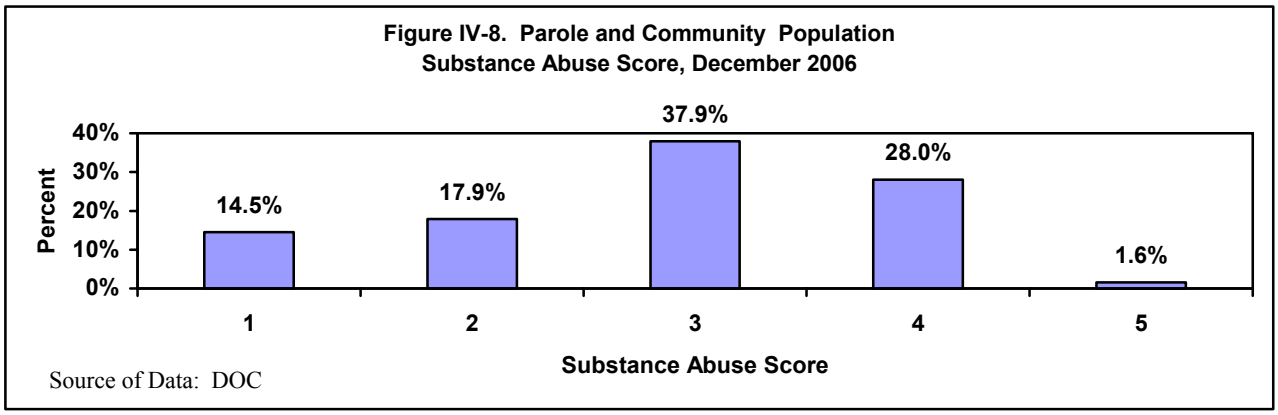


Source of Data: DOC

Caseloads and admissions. As noted above, on average about 8,200 offenders were released in the last year to the parole division, and about 4,300 offenders are under the supervision of this division on a daily basis. The Parole and Community Services staff supervises an average combined parole/transitional supervision caseload of 49 persons per officer. Specialized caseloads, such as sex offenders, are usually smaller at 25-30 cases per officer. There were 1,455 admissions to parole in FY 08 and 896 remands to custody. There were 692 admissions to special parole and 498 remands to custody; for TS there were 3,075 admissions and 1,117 returns to custody in FY 08.[42]

Substance abuse score. Figure IV-8 shows the distribution of T-Scores for the DOC parole and transitional supervision population at the end of 2006. While nearly 85 percent of inmates coming onto parole or TS have some level of substance abuse history (i.e., a T-Score of 2 or more), about 68 percent have a score that requires an intervention with formal treatment programming (i.e., T-Score of 3 or more). This means that about 5,600 offenders entering parole would be in need of substance abuse treatment. It is not know how many offenders do not receive all the treatment needed because their sentence or incarceration ends before treatment is completed.

[42] Special parole is a form of parole that is mandated by the court in place of probation. It is generally reserved for high risk offenders.



Parole Division: Intake, Assessment, and Referral Process

For each inmate who has been "voted to parole" by the Board of Pardons and Parole, the Parole and Community Services Division receives a packet of information from the parole board that contains the standard conditions of parole and any other conditions that the board may impose for the individual along with a parole summary. The packet also contains historical information about the offender including pre-sentence investigations, sentencing transcripts, police reports, and information on any DOC activities that the offender may have engaged in.

The information the division receives from DOC correctional facilities for pending transitional supervision offenders is similar except it does not include a parole summary and related documents that would be generated by the parole board. Parole and community services officers (who are called parole officers) also have access to DOC electronic case management information and records.

For parolees, the parole board uses DOC- generated assessment information as a basis to stipulate any special conditions on offenders, like substance abuse treatment, when making release decisions. The parole board does not perform any independent assessments of offender needs. The parole board does administer the Salient Factor Score (SFS), which is an assessment instrument used to examine an offender's likelihood of recidivating following release from prison. The board uses the information generated by the SFS to guide release decisions. The SFS, though, is a static prediction instrument (measuring only information at the time the offender was sentenced) and consists of only five risk factors. Thus, the SFS examines only the risk of recidivating and not the needs of the offender. Those needs are indicators of where criminal justice agencies should intervene and work to modify to reduce recidivism. Thus, the needs of paroled offenders are assessed by the DOC parole division, as described below, after the parole board has acted. The DOC parole division has the authority to add requirements to an offender's release conditions.

Assessments. Parolees are required to meet with a DOC parole officer within three days of release from a DOC facility. The parole officer will review the parole agreement with the parolee and other conditions of his or her release. As a DOC requirement, all parolees receive a substance abuse assessment by a community provider generally within 10 days of release from a

DOC facility. While there is no standard instrument, the parole division requires its providers to use evidence-based assessment tools. The division reports that most providers use the Addiction Severity Index or the Adult Substance Use Survey (ASUS) assessment tool.

The level of need is determined by the assessor, and it is assumed the assessor is factoring in any treatment obtained while the offender was incarcerated. While there are no standard treatment protocols required by the parole division, the division does require an individualized treatment plan be created. The assessor also, in most instances, is the provider of substance abuse services. The parole division does not independently check on how an offender's needs match with the intensity of services delivered.

The parole officer receives information back from the provider regarding parolee noncompliance and program completion. Monthly reports are also received by the division indicating the aggregate amounts of activity (e.g., number of evaluations, admissions, toxicology screens, and individual and group sessions) by provider.

The parole division is in the process of changing its approach to assessing offender risk and needs by incorporating the administration by its own parole officers of the Adult Substance Use Survey and the Level of Service Inventory – Revised. The division is beginning to use these tools as a more sophisticated and evidence-based approach to determining the level of supervision an offender requires and in identifying the needs that should be addressed. As of September 2008, parole officers are undergoing intensive training to administer the two instruments. The changes were to be implemented during the fall of 2008. The Judicial Branch's Court Support Services Division was assisting the parole division with this training.

The results of these assessments performed by parole officers will be incorporated into a case management plan created in collaboration with the offender. The case management plan is intended to address the offender's needs that most directly contribute to the risk of recidivating consistent with the results of the LSI-R sub-scales.[43] Similar to CSSD, it is expected that the offender will address the top three criminogenic needs during the term of supervision. Once the new process is fully implemented, the providers will no longer be required to do assessments.

A number of other requirements must be satisfied in order for an offender to be released into the community. For example, depending on the risk level of the offender, a sponsor usually must be identified by the offender in order to live in the community as opposed to alternative housing (e.g., halfway house).

Treatment programs. The parole division maintains a wide network of contracts with private non-profit community providers for residential and nonresidential supervision and treatment of offenders. Currently, 49 residential and 36 nonresidential providers work in collaboration with parole officers to provide an array of residential and treatment services. All levels of substance abuse treatment are available through this non-profit network.

Treatment is not the only consideration in determining offender placement in the community. The offender's risk of noncompliance and risk to recidivate also is considered.

[43] See earlier discussion of LSI-R scales in Chapter III.

Offenders on transitional supervision are generally afforded greater freedom than parolees, while offenders placed in residential programs have a more structured environment.

All substance abuse programs under contract with DOC are required to use evidence-based practices. These practices may or may not be validated for criminal justice populations. The providers that act as a referral service for offenders may send offenders to DOC programs or other programs that do not have evidence-based requirements, though the treatment programs are mostly likely DMHAS- funded.

Residential programs. The parole division maintains two broad types of housing: halfway houses and alternative or supportive housing. Halfway houses provide 24-hour supervision and offer a range of different services as described below. Supportive housing provides supervision to male and female offenders who lack appropriate living arrangements, while assisting them obtain services in the community and preparing them to function independently.

Taken together the number of contracted residential program beds is about 1,290, which are offered through 49 providers. All the housing options offer substance abuse education, counseling, or referral to treatment providers or aftercare services. Table IV-4 describes each of the programs, the treatment timeframes, and the number of beds available for each.

Table IV-4. Parole & Community Services Division Residential Programs

Program	Program Description	Time	No. Beds	No. Served FY08
Halfway House Programs				
Work Release	Work Release programs assist male and female offenders obtain gainful employment while providing secure on-site supervision. Individual treatment plans are developed for each offender with a focus on: meaningful employment, substance abuse education, life skills, and discharge planning. Some programs offer cognitive behavioral education programs and abuse and mental health services on-site ,and in others referrals are made to DOC nonresidential programs.	4 to 6 months	766 beds	2,366
Inpatient Substance Abuse Programs	Inpatient programs use a comprehensive evidence-based screening assessment tool that identifies problem areas to be addressed in an individualized treatment plan. Substance Abuse programs are highly structured environments, based on a cognitive behavioral treatment approach, offering relapse prevention, N/A & A/A, group therapy, and family counseling. Discharge plans include community aftercare referral for continuity of care. (Cont. next page)	30 days to 8 months	207 beds	641

Table IV-4. Parole & Community Services Division Residential Programs				
Program	**Program Description**	**Time**	**No. Beds**	**No. Served FY08**
Mental Health Program	Mental Health programs are highly structured environments offering mental health treatment, group therapy, family counseling, substance abuse treatment, and discharge planning. The mental health programs work with the local LMHA and DMHAS to enhance continuity of care while transitioning offenders on parole, Transitional Supervision, or end of sentence.	6 to 8 months	23 beds	63
Women & Children Program	Women & Children programs offer female offenders residential social reunification programming, in addition to substance abuse counseling. In conjunction with DCF, offenders are reunited with their children prior to parole, Transitional Supervision, or end of sentence.	4 to 6 months	31 beds	77
Alternative Housing				
Supportive Housing	Supportive housing designed for offenders on Transitional Supervision or parole that are in need of transitional housing. Supportive housing is provided in both scattered-site and congregate settings. The goal is to assist offenders in reestablishing themselves in society. Congregate houses are supervised houses that have house managers available 40 hours per week and initiate referral to community resources, including substance abuse treatment, based on client need. Congregate houses are chemical-free environments. Scattered site housing refers to individual apartments where offenders are placed to have the offender function independently. Staff provides extensive case management services that include the development of an Individual Case Service Plan, employment supports, securing entitlements, linking and referring to mental health, substance abuse, and other community-based social services.	4 to 6 months	270 beds	118 Congregate 655 Scattered
CSSD co-contracted	Beds are filled with accused (pre-trial) and sentenced individuals age sixteen (16) years and older. Parole officers may refer to these programs when an offender needs a higher level of support than can be offered at an Alternative Incarceration Center. Other DOC offenders who need residential housing may utilize these beds. Program services include: intake assessment for risk and need, case management, substance abuse assessment, group intervention (employment, cognitive skills, substance abuse), and community service restitution		77	85
Source of data: DOC				

Of the 1,290 beds on line, 909 beds were for male offenders, 120 for female offenders, and 263 were mixed gender. The average cost per bed is $23,700. In addition to receiving counseling, employment assistance, and substance abuse and mental health treatment, offenders in community residential programs work in the community and are thus required to pay taxes and rent, and, if applicable, victims' compensation and child support. Daily occupancy rates averaged nearly 100 percent, though there are no waiting lists for residential services. DOC has 77 beds co-contracted with CSSD through the collaborative contracting arrangement discussed above.

Non-residential programs. Thirty-six nonresidential programs provide a variety of services to offenders including outpatient substance abuse counseling, mental health evaluation and treatment, anger management, domestic violence education, employment assistance, individual, couples and family counseling, family training, child care education, transportation and other social services.

Only two types of services provide direct substance abuse treatment. There are no waiting lists for nonresidential programs. Table IV-5 provides a description of those non-residential programs that have some substance abuse treatment component with the treatment timeframes and number of clients served in FY 08 (duplicates are possible).

Discharge plans and aftercare. Each residential and nonresidential provider is required to develop a discharge plan for each offender within 15 days of discharge. While the nonresidential plans are less formal, the residential provider discharge plans must include a brief summary of the offender's participation in the program, future housing arrangements, substance abuse treatment recommendations, employment and vocational objectives, and utilization of support systems.

Split sentence. It should also be noted that many previously incarcerated offenders are transferred to the custody of the Judicial Branch because they have a split sentence. A split sentence requires the inmate to serve a period of probation after incarceration. This is in contrast to an offender being paroled by the parole board after a period of incarceration and under the custody of the Department of Correction. The Judicial Branch and DOC maintain a memorandum of understanding that facilitates the transition of these offenders.

Because research has shown that the first days of release are critical in successful completion of probation, CSSD created the Probation Transition Program (PTP) which targets inmates 90 days prior to release who have a term of probation following their discharge from correction custody.

Probation officers from CSSD conduct a needs and risk assessment within 45 days prior to placement on probation for the split sentence offenders. The DOC parole officer is required to furnish the CSSD probation officer with a status report that includes a list of programs in which the offender is currently enrolled or has already completed. If an offender is participating in a treatment program while transitioning to the outside, the two departments are supposed to take steps "when possible" to allow the offender to complete the program while under probation supervision.

Table IV-5. Parole and Community Services Non-Residential Providers			
Program	**Description**	**Timeframe**	**No. Served FY 08**
Multi-Service Centers	Multi-Service Nonresidential Programs provide a wide variety of social service assistance directly or through referrals. These programs are able to provide "one stop shopping". All programs provide care management and aftercare services. Offender needs addressed include: • employment and vocational training, • housing, • substance abuse treatment, • mental health and psychiatric services, • social reunification services and educational advancement, • legal identification, and • vouchers for food and clothing. Programs provide an individualized service and community integration plan that is sensitive to cross-cultural and gender specific issues. Programs are expected to demonstrate linkages to the community at large.	Typically 90 days	3,920
Substance Abuse	Substance abuse nonresidential programs provide intensive outpatient substance abuse treatment services. The programs utilize a risk reduction treatment approach that is based on an in-depth assessment of the needs of the offender utilizing evidence-based instruments. Treatment services utilize an intensive outpatient treatment model stressing the importance of the development of a supportive family network. Substance abuse programs offer the offender the opportunity to attend group therapy (2-6 groups per week) that may include couples therapy and family therapy. Most programs have the capacity to treat co-occurring disorders (mental health and substance abuse). Through a cognitive behavioral approach, the programs address offender needs regarding problem solving, coping strategies, lifestyle changes, and alternative positive approaches to manage addictive behavioral patterns. Most of the nonresidential substance abuse programs are licensed by the Department of Public Health.	60-120 days	3,460
Source of Data: DOC			

Chapter V

Agency Monitoring Activities and Best Practices

The quality of substance abuse treatment services provided to adults in Connecticut is regulated, reviewed, and assessed in a variety of ways. The Department of Public Health (DPH) requires licensing for private providers of clinical care at all levels -- inpatient, residential, or ambulatory/outpatient-- and for professional clinical staff who provide substance abuse treatment services. Many treatment facilities and programs in Connecticut also participate in national accreditation processes, such as those carried out by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, and the Council on Accreditation.

Furthermore, DMHAS, CSSD, and DOC each carry out their own substance abuse treatment monitoring and quality assurance activities. For example, all three entities included in the committee study fund treatment programs for adults and have established their own policies and procedures for assuring external providers comply with grant and/or contract provisions related to quality. In addition, the two agencies that operate treatment programs (DMHAS and DOC) have internal quality assurance standards and quality improvement processes that pertain to clinical services they provide directly. Both departments as well as CSSD also have established ways to evaluate and conduct research on the efficiency and effectiveness of the alcohol and drug services provided to their clients.

This chapter provides an overview of the efforts made by the Department of Mental Health and Addiction Services, the Court Support Services Division, and the Department of Correction to provide and promote effective treatment for their clients with substance abuse problems. Separate descriptions of the main monitoring and quality assurance activities of DMHAS, CSSD, and DOC, both for its facility-based and its parole-based populations, are included in this chapter.

In addition to generally accepted models for effective quality assurance, research specific to substance abuse treatment has identified certain practices that contribute to successful outcomes. These include agency policies and procedures related to: 1) substance use testing; 2) evidence- or research-based practices; 3) discharge planning and aftercare; and 4) external credentialing. The following descriptions highlight how each agency has incorporated generally recognized “best practices” related to all four areas within its substance abuse treatment programs.

The descriptions also include information PRI staff compiled about the outcome and performance measures all three entities use to monitor their substance abuse treatment services and any internal and external research projects conducted on treatment effectiveness. Finally, this chapter contains information committee staff were able to gather on the resources each agency allocates to its quality assurance activities for substance abuse treatment, as well as on the agency data systems that support monitoring and performance evaluation efforts.

Department of Mental Health and Addiction Services

Within the Department of Mental Health and Addiction Services, the Health Care Systems (HCS) Division has primary responsibility for quality assurance and quality improvement functions related to the agency's network of contracted behavioral health service providers. It also has certain monitoring responsibilities for the state-operated treatment programs at DMHAS facilities.

Another division, Evaluation, Quality Management and Improvement (EQMI), supports the Health Care Systems program monitoring function by assuring the quality of the client and service data within the department's automated information systems for all external providers and for its own facilities. EQMI staff also capture and report certain program-based information (e.g., monthly provider performance reports) and has some capacity to analyze key operational data, such as critical incidents (e.g., client death or serious injury) or the use of client restraints and seclusions, for specific providers, levels of care, or the overall system.

At present, the HCS staff oversee approximately 200 private, primarily nonprofit, mental health and substance abuse programs funded through DMHAS grants and/or fees-for service. Almost half (89) provide clinical substance abuse treatment services, from inpatient detoxification to outpatient counseling, to DMHAS clients. The division also monitors 79 private providers that receive state and federal funding to carry out certain recovery support programs (e.g., housing, transportation, vocational/employment assistance, and other nonclinical services) targeted to help clients with alcohol and drug abuse problems.

The HCS division's main monitoring efforts, highlighted below, are aimed at: checking private provider compliance with state and federal regulations and DMHAS standards, policies, and contract requirements; ensuring access to and delivery of quality services that meet client needs; and assuring consistent service delivery statewide. For providers that receive grant funding from the agency, division staff check on compliance with the provisons of their related human services contracts. The division also is reponsible for reviewing compliance with the requirements of fee-for-service agreements that apply to providers participating in the department's managed care program, the General Assistance Behavioral Health Program..

Of the 89 substance abuse treatment providers currently funded by DMHAS, 40 are nonprofit programs that receive state grants to provide clinical services to the department's client population. (Only nonprofit agencies are eligible for state human services grants.) All but one of these grant-funded nonprofits also participate in the agency's fee-for-service managed care program. Another 52 private providers, including 25 general hospitals, provide clinical treatment services to eligible adults with substance abuse disorders <u>just</u> on a fee-for-service basis through GABHP. There is one additional general hospital that receives both GABHP and grant funding.

Monitoring and quality assurance. Routine monitoring activities carried out by HCS staff to assess quality and compliance of substance abuse providers include:

- semi-annual desk analyses of every funded provider as well as state-operated programs;

- on-site program reviews of varying intensity, as needed, based on desk analysis results, and at least every two years;
- bi-annual on-site program review meetings with top management of each provider;
- analyses of grant application provisions each funding cycle; and
- focus groups and client/consumer interviews during site visits, and as needed.

Desk analyses are twice yearly reviews of program data reports prepared by the EQMI Division and the agency's fiscal and information technology offices that permit HCS staff to compare key measures of provider performance to benchmarks, statewide averages, agency standards, and contract requirements. Results from the department's annual consumer survey, which include several indicators of client and family satisfaction with services, also are reviewed during a provider desk analysis.

Results of each desk analysis are summarized in a written report that identifies areas of concern, noncompliance issues, and program strengths, and contains any staff recommendations for improvement. Reports that find unfavorable results trigger additional monitoring, such as on-site visits by the division staff, and can require the provider to prepare and implement a corrective action plan (CAP). All private providers are visited by HCS staff at least once every two years that involves, at a minimum, a meeting with the agency leadership to go over operations and performance.

In addition to routine monitoring activities, HCS staff are responsible for following up on all critical incidents that occur in state-funded private provider programs, as well as consumer complaints related to any of the agency's mental health and substance abuse services. Site visits and corrective action plans can be triggered by what the division calls "egregious" critical incidents (e.g., a client death) and complaints or if other DMHAS divisions have major concerns (e.g., fiscal issues, or failure to submit required data reports) about programs. Nonroutine monitoring also can occur when HCS staff are notified of provider licensing issues by the Department of Public Health or disciplinary actions taken by other funders or regulators (e.g., federal agencies or accreditation organizations).

According to the division director, at any time HCS staff are tracking the compliance progress of between 10 and 15 mental health and substance abuse provider CAPs. On average, division staff conduct about 10 provider site visits per month, which may be focused (limited to reviewing specific concerns) or comprehensive (thorough review of entire operation).

Providers found in compliance with contract requirements and department standards are determined to be "In Good Standing," meaning additional monitoring or special conditions, such as limits on service expansion or funding restrictions, are unnecessary. Programs in need of corrective action are placed in one of three HCS division categories that correspond to increasingly intensive levels of oversight, depending on the severity of the provider's deficiencies. These range from periodic written progress reports or phone calls ("Watch List"), to monthly reports and quarterly on-site meetings ("Under Review"), to biweekly reports, monthly on-site meetings, quarterly reviews, and funding/service restrictions ("Under Serious Review").

In nearly all cases, it appears the department is able to work with providers to resolve compliance and performance issues satisfactorily with its corrective action process. The HCS director noted, over the past two years, only one provider has been defunded and another, at the department's suggestion, shifted its program from residential treatment to a lower level of care (i.e., a recovery house). According to the director, providers return to good standing within 12 months about 90 percent of the time.

During FY 08, the division conducted desk analyses for 62 substance abuse provider agencies. At the end of the fiscal year, 55 (89 percent) were in good standing; seven agencies were under review or serious review. Most were expected to return to good standing within a year.

A total of 16 provider agencies encompassing 44 different substance abuse treatment programs received either a focused or comprehensive site visit by the division's regional teams during FY 08. HCS staff also visited 14 providers as a result of complaints or critical incidents.

The division does not aggregate information about compliance and performance issues included in corrective action plans or noted during site visits. However, the HCS director reports the most frequent areas noted for corrective action are: data documentation; data submission; documentation of service quality and frequency; and underutilization.

Other contract compliance. As noted above, the division has oversight responsibility for the department's managed behavioral health care and recovery supports programs. One of its main duties is to monitor adherence by the program's Administrative Service Organization (ASO), Advanced Behavioral Health, with its contract provisions.

Compliance with administrative performance standards and with agency policies regarding the GABHP and Access to Recovery (ATR) programs is checked primarily at twice monthly meetings held with ASO management staff and by reviewing monthly data reports generated by the ASO. For example, the division's GABHP program supervisor receives reports on: timeliness of response (to provider and consumer telephone calls); claims processed; clinical reviews and authorizations; denials and appeals; and provider and consumer satisfaction ratings. According to the department, the ASO's performance to date has been satisfactory.

HCS staff also review routine provider profile reports produced by the ASO, which include admissions data, utilization rates, length of stay information, and certain performance measures. At present, the profile reports are generated twice a year and mailed directly to the provider agencies. The department can and does request the ASO to generate ad hoc reports in order to look at trends and patterns among the different client populations, types of services, levels of care, geographic areas, or other areas of special interest for monitoring or planning purposes. GABHP and ATR payment data are reviewed every week by the agency fiscal office and cost information is also included in provider profile reports submitted to HCS monitoring staff.

State-operated programs. As described in Chapter II, DMHAS operates inpatient treatment programs for adults with substance use disorders at three state facilities and directly provides outpatient services at another state facility operated in cooperation with Yale

University. At the time of the committee's study, the department's monitoring and quality assurance process for its state-operated programs was in transition. In addition, there was little centralized operational or outcome information available on the state-operated alcohol and drug treatment programs.

Furthermore, the agency's automated data system for its facilities was in the process of a major upgrade. The existing system produces little management information and is of limited use for reporting even basic performance data from state-operated programs. To meet a PRI staff request for client and service information (e.g., admissions and discharges, length of stay, and utilization by level of care), data had to be obtained separately from each facility. While each facility has developed its own systems and databases for monitoring and reporting purposes, they appeared to vary in quality and capacity.

PRI staff toured one DMHAS substance abuse treatment facility (Connecticut Valley Hospital) and interviewed selected staff to gain a better understanding of how state-operated programs are monitored. Based on this field work, it was determined multiple site visits of all four DMHAS facilities programs would be required to fully assess their quality assurance processes. This was not feasible with the study timeframe. Therefore, the following description highlights the main central office oversight activities in place at the time of the committee study.

Under a relatively recent reorganization of agency top management (effective March 2008), all state-operated mental health and substance abuse programs report to one deputy commissioner. Routine reporting requirements and other monitoring procedures for the state-operated treatment programs are still being developed by this deputy commissioner.

At present, the deputy commissioner reviews the critical incident reports from all state-operated programs and monthly readmission rate and daily census reports from the state residential treatment programs. The EQMI division prepares monthly performance profile information for the state-operated substance abuse treatment programs, as well as regular analysis of seclusion and restraint data from the inpatient programs. According to the division director, one way managers use this information is to develop training initiatives and other support for inpatient treatment programs with higher than expected use of seclusion and restraints.

The department's health care systems staff also conduct semi-annual reviews of performance data from the state-operated substance abuse treatment programs. Unusual trends or concerns based on the review are reported to the deputy commissioner for state facilities. If requested by the DMHAS executive team, the division's regional teams will conduct site visits to follow up on complaints received about state-operated programs. The department was unable to provide monthly performance reports or any summary of information based on HCS reviews or site visits of state operated programs to PRI staff in time for inclusion in this report.

While DMHAS substance abuse treatment programs are not subject to DPH licensing requirements, all department facilities are nationally accredited. In accordance with accreditation requirements, the facilities must have certain quality assurance and improvement procedures in place. For example, each department facility has an internal quality improvement team or committee for its substance abuse treatment programs that, among other duties, reviews critical

incidents and audits compliance with clinical practice standards (e.g., treatment planning, supervision, and client record documentation).

Samples of internal quality improvement materials provided to PRI staff indicated the state facilities have similar, but not standardized, processes. The DMHAS central office has not compiled information about each program's quality assurance policies, procedures, or structure. In addition, the department has: no inventory of the types of assessment tools, treatment programs, or evidence-based practices in place at each state-operated program; no centralized information on wait lists and other access indicators at each facility (other than the daily census report); and no single source of information on licensure/certification status of each program's clinical professionals and counselors.

System monitoring. On a regular basis, the HCS Division director reviews certain standard reports on provider performance to assess the overall network of mental health and substance abuse treatment services. These include: the monthly provider profile reports prepared by EQMI that summarize compliance with data quality standards as well as key performance measures; the semi-annual, as well as any ad hoc, performance reports produced by the ASO for providers certified to participate in the General Assistance Behavioral Health Program; summaries of the regional team desk analyses; and daily census and other utilization rate reports compiled for all state-funded or –operated residential treatment programs.

Currently, provider performance information from all sources is not aggregated or complied into any type of "report card" document for the service system, although that concept has been under discussion at DMHAS. Further, the department does not, on a routine basis, share the provider performance and outcome information it develops with other state agencies that fund substance abuse treatment services for adults. One exception is provider site visit reports completed for the residential programs that are part of the collaborative contract; those are shared with CSSD and DOC. Additionally, the department's annual consumer satisfaction survey results are forwarded to the correction department commissioner and the CSSD director.

Selected best practices. As the state's lead substance abuse agency, DMHAS is responsible for setting policy and practice standards for all publicly funded or provided treatment services for adults. The department's application of the selected best practices related to effective substance abuse treatment that were identified and reviewed as part of this study (i.e., testing, evidence/research-based practices, aftercare, credentialing) is summarized below.

Substance use testing. Under DPH regulations, licensed providers that operate detoxification and/or chemical maintenance programs have provisions in place for regular urine testing. DMHAS has guidelines concerning testing for substance use during certain types of treatment but has not adopted any general policy about testing practices including consequences for positive results.

Some agency contracts do contain provisions regarding drug screening (e.g., the collaborative contract with criminal justice agencies for residential treatment services requires random testing on all CSSD and DOC program participants at least once per week). In addition, the minimum criteria for GABHP certification for some types of treatment programs require certain drug use screening procedures. Information about provider testing policies and

procedures, or the results of such activities, is not compiled and analyzed. On an individual basis, HCS regional teams would review a provider's substance use testing activities during their on-site monitoring visits.

Evidence- or research-based practices. Providers are encouraged under DMHAS policies and guidelines to use evidence-based practices, including Motivational Interviewing and Motivational Enhancement Therapy, as well as what the department has identified as best practices, such as trauma-informed, gender specific, and culturally competent care. The agency requires evidence-based or best practices for some specific types of care (i.e., chemical maintenance, two types of enhanced co-occurring care, and one kind of outpatient treatment).

Training and technical assistance on a variety of evidence-based and best practices is offered to department staff and employees of contracted providers through the DMHAS Education and Training Division. The department does not compile information on the types or amounts of training in evidence-based practices the employees of substance abuse treatment programs have received. A database of individuals who participate in any of training division offerings is maintained.

Under the department's *Practice Guidelines for Recovery-Oriented Care (2nd edition)*, services and supports funded or directly provided by the agency are expected to be consistent with the following national Institute of Medicine quality measures: person-centered; timely/responsive; effective; equitable; efficient; and safe. The guidelines also expect providers to use best available practices that are linked with positive outcomes on the basis of expert opinion, promising research, or scientifically established evidence.

In a few cases, programs are required by contract or by GABHP certification criteria to employ an evidence-based treatment model (e.g., certain intensive outpatient programs funded by DMHAS must use the evidence-based "Matrix" model of care). Many DMHAS providers are known to incorporate evidence- and research-based practices within their substance abuse treatment programs. However, there is no centralized inventory that describes what types of care and services are available through the state-operated and -funded alcohol and drug abuse treatment system.

As part of their monitoring site visits, HCS staff may review model fidelity if specific treatment or service designs are required, such as some evidence-based and emerging best practices. This appears to occur infrequently; recently, some effort has been made to monitor certain best practices related to co-occurring disorders. Also, in the past, particularly for mental health programs, providers have been sent materials to conduct self-assessments of fidelity to evidence-based practice models, which were then reviewed by HCS staff.

The department does not conduct any formal, systematic assessment of the therapeutic alliance between a program's treatment staff and their clients. However, HCS staff do interview program participants and/or conduct focus groups during site visits to get feedback from clients on their treatment experience. Data on client satisfaction ratings of treatment program staff also are collected through the annual consumer survey.

The department recently mandated all of its funded and operated behavioral health programs to use standardized screening tools, which are scientifically validated tools recommended by SAMHSA, to identify clients at risk of co-occurring conditions during the admission process. Substance abuse program providers are required under DPH regulations and DMHAS policy to conduct a complete biopsychosocial assessment of all clients admitted for clinical treatment.

In addition, as discussed earlier, all providers must use certain standardized criteria for pre-admission screening (i.e., the department's Connecticut Client Placement Criteria, which are based on the American Society of Addiction Medicine criteria). However, the department does not specify any particular instrument or group of evidence-based assessment tools be used.

State law and department policy do require that clinical substance abuse treatment services, which include assessment and treatment planning, be performed by, or under the supervision of, a licensed health care practitioner. It is possible, therefore, for staff members who are not licensed or certified, to conduct assessments (and perform other clinical services) if supervised by credentialed clinicians. Supervision is not specifically defined in statute or regulation; it appears, based on discussions with DPH staff, that review of noncredentialed staff who provide clinical services by a licensed professional clinician must occur at least weekly.

According to DMHAS staff, most providers use one or more of the many evidence-based assessment tools available for determining client alcohol and drug abuse treatment needs and planning appropriate clinical and support services. Information on the substance abuse assessment instruments and procedures used by treatment programs, or their supervision policies for staff who are not licensed or credentialed, is not compiled by the agency's monitoring units.

Discharge planning/aftercare. DMHAS clients, in accordance with state law and/or regulation, as well as agency policy, must be treated in accordance with individualized treatment plans that include plans for discharge that address appropriate aftercare. Department policies and guidelines emphasize the importance of providing aftercare and recovery supports to sustaining positive treatment outcomes. At this time, data on the number of substance abuse clients who receive services to support their recovery following treatment, the types of services provided, and outcome information related to aftercare, are not tracked systematically by the department.

The department, as required by federal grant requirements, does conduct follow-up interviews six month after intake with individuals participating in the Access to Recovery program; at least 80 percent of all clients must be interviewed about the outcomes of the services they received. DMHAS also gathers some information about the aftercare services provided through its Telephone Recovery Support program, described briefly below. Data on referrals made at time of discharge are gathered through the department's substance abuse provider information system but are not compiled and analyzed at this time.

The value of nonclinical services that support recovery like housing, transportation, employment assistance, and help with basic needs, is widely recognized. However, resources for these services for DMHAS clients are limited. The only widely available services for adults in recovery are community-based self-help groups like AA and NA. DMHAS recommends that all

of its funded providers and state-operated programs, when discharging clients, make referrals to community-based self-help organizations.

At present, DMHAS operates two main recovery support programs, the federally funded Access to Recovery program and the state-funded General Assistance Recovery Supports Program (GA RSP). Now in its second phase, the Access to Recovery program (ATR II), is focused on providing a broad range of recovery support services and assistance to adults with alcohol and drug abuse problems, with an emphasis on those who are involved in the criminal justice or child welfare systems. Services also are available to those DMHAS clients with an opioid dependence for which buprenorphine is an appropriate treatment. Over the three-year funding period of ATR II, the department expects to serve about 9,000 individuals, with federal grant monies totaling about $14.5 million.

The state GA Recovery Supports Program helps with housing and other basic needs (e.g., food, clothing, personal care items) for eligible SAGA clients who are engaged in mental health or substance abuse treatment. Over the past three years, the state recovery support program has served about 7,000 individuals a year.

DMHAS also has undertaken several initiatives that provide intensive case management for certain SAGA clients identified as having serious challenges achieving and maintaining recovery. Two of its General Assistance Intensive Case Management Program initiatives targeted to clients with substance use disorders are: Alternative to Hospitalization, which diverts clients from emergency rooms to more appropriate co-occurring residential services; and the Opioid Agonist Treatment Protocol (OATP), which helps opioid dependent clients with frequent readmissions to residential detoxification programs enter less intensive treatment such as methadone maintenance and receive recovery supports.

Even taken together, the agency's various recovery support initiatives can serve only a portion of the thousands of adults who receive care through the state's substance abuse treatment system and could benefit from such services. Recognizing this unmet need, the department began funding telephone recovery support services in 2004 as a relatively low-cost way of providing some level of aftercare to more of its substance abuse client population. The Telephone Recovery Support (TRS) program was expanded statewide in 2007 and is carried out by the nonprofit community-based organization, Connecticut Community for Addiction Recovery (CCAR) .

Through this program, adults newly discharged from a substance use treatment program receive a phone call once a week for at least twelve weeks from trained volunteers to check on their recovery. The volunteers provide encouragement to those who are sustaining recovery and can assist individuals reporting a relapse to return to treatment if necessary. As of January 2008, there were almost 500 individuals enrolled in the CCAR telephone support program.

To promote participation in the program, DMHAS recently recommended strongly that providers make clients aware of the telephone recovery support program at time of admission to treatment. The department also recommends providers seek each client's permission to give the program operator his or her contact information.

External credentialing. All private providers funded by DMHAS must be licensed as substance abuse treatment facilities by DPH. Many private providers funded by the department also are accredited by the Commission on the Accreditation of Rehabilitation Facilities or the Joint Commission. DMHAS does not maintain aggregated information on the accreditation status of its private providers.

DMHAS has established its own, additional certification process for providers that participate in GABHP. Certification requirements were developed for each level of care that set standards in addition to public health department licensing regulations. These include minimum criteria, relevant to each type of treatment program, related to: facility accreditation; staff credentials, admissions, and assessment procedures; discharge planning and referral to aftercare; drug screening; and educational and therapeutic programming.

The GABHP certification form also gathers supplemental information from each provider about: access to services (e.g., availability of assessment within a certain timeframe); coordination of care (e.g., communication policies with other providers regarding shared clients); procedures for handling clients with co-occurring disorders; and use of evidence-based practices. Specific data are gathered regarding the client population served, language competence of staff, problems and disorders treated, and program specialties (i.e., types of services and therapies provided in which two or more staff have education, training, and supervised experience).

Providers of services funded through the department's Access to Recovery program are subject to a similar certification process. However, none of the detailed program or supplemental information gathered through either certification process is aggregated or compiled as any type of provider profile report by DMHAS.

All professional health care providers (e.g., physicians, nurses, psychologists, professional counselors and social workers) employed by the DMHAS funded or any state-operated substance abuse programs must have appropriate licenses from the Department of Public Health. DMHAS, however, does not require that all staff providing clinical services to clients of alcohol or drug programs it funds or operates be credentialed. Direct care staff who may provide alcohol and drug counseling and conduct assessments do not have to be licensed or certified.

As noted above, state law does require noncredentialed staff of substance abuse treatment facilities to be supervised by licensed professionals if they render clinical services, although supervision is not defined in either statute or regulation. Supervision requirements for staff who are not licensed or certified are outlined in the DMHAS minimum criteria for GABHP certification and program policies.

DMHAS does not maintain centralized information on the license/certification status or education, training, and experience of staff at its funded or operated substance abuse treatment programs. A survey conducted by the department in 2002 indicated just over 90 percent of all addiction counselors working in the state-operated or -funded programs that responded to the survey (80 percent) had at least a college-level associate's degree; experience in the addictions field averaged almost 10 years.

Source data for the survey could not be located and the information has not been updated in any systematic way. However, the department is beginning to examine a number of behavioral health workforce issues, partly in response to a projected shortage of qualified substance abuse and mental health clinical staff, as well as high staff turnover rates many providers are experiencing. Through its federally funded Mental Health Transformation imitative, DMHAS is creating a permanent public-private body (the Connecticut Mental Health Workforce Collaborative) to plan, coordinate, and implement interventions to strengthen the behavioral health workforce.

Outcome and performance measures. DMHAS collects a considerable amount of performance and outcome data regarding all the behavioral health services it funds and operates. As discussed above, detailed information about substance abuse clients and treatment services is gathered through two provider information systems (i.e., the SATIS and GABHP automated data systems) and is the basis for: 1) information on outcome measures included in the agency's provider profiles and performance reports; and 2) tracking compliance with outcome measures contained in provider contracts.

National outcome measures. Much of the outcome information gathered by the department is mandated by federal law and block grant funding requirements. Annually, all states must report to SAMHSA on National Outcome Measures (NOMs) related to mental health services and substance abuse treatment and prevention. At present, the NOMs for substance abuse treatment are:

- Abstinence from *alcohol and drug use* or decreased use;
- Increased/retained *employment/education* participation;
- Decreased *criminal justice involvement*;
- Increased stability in *housing/living arrangement*;
- Increased social supports/*social connectedness* (e.g., as federal indicators are still under development, Connecticut uses participation in community-based self-help groups for this measure);
- Increased *access* to services (i.e., service capacity as measured by unduplicated counts of persons served and penetration rates); and
- Increased *retention* in treatment (length of stay data).

Three additional substance abuse treatment NOMs related to client perceptions of care (gathered through consumer surveys), cost effectiveness, and use of evidence-based practices still are under development by SAMHSA. There is little or no state reporting in these areas at this time and no federal requirement to do so.

DMHAS uses the five NOMs that concern client status in terms of substance use, employment, crime, housing, and social supports to evaluate its funded and operated substance abuse treatment programs. (The access and retention measures are treated by the department and SAMHSA as system performance indicators.) The department also requires providers to report on, and regularly review, four additional outcome measures related to substance abuse treatment effectiveness:

- *Treatment completion* (based on client discharge status, to measure how many persons admitted to a program complete it);
- *Improved functioning* (based on changes in a client's GAF score, which is a standardized assessment of ability to function, to measure overall progress toward recovery);
- *Connection to care*/continuity of care (based on discharged clients receiving treatment services at a less intensive level within a certain timeframe, to measure whether clients connect with further appropriate treatment to facilitate recovery); and
- *Readmission* (based on discharged clients receiving treatment services at an equally or more intensive level within a certain timeframe, to measure whether clients cycle repeatedly through the same levels of care or continue toward recovery through programs of decreasing intensity).

Some NOMs information is posted on the agency website and reported in the agency's federal block grant application during the public comment period. However, neither the national outcome data nor the department's other provider performance information are routinely aggregated or periodically summarized and reported to the public. At the request of PRI staff, the department compiled treatment completion and certain NOMs for the major components of the state system over a three-year period.

Table V-1 shows treatment completion rates for adults discharged during three recent fiscal years, overall and by level of care. (Methadone maintenance program data are not included here.) The rate is the number discharged as completing treatment divided by the total number admitted to the care level (excluding those with missing matching data). Completion is defined as having a discharge status of completing treatment with or without referral to another level of care, or having left treatment with staff advice and a referral (e.g., transferred to another level of care).

Table V-1. Connecticut Treatment Completion Rates by Level of Care: Percent Completing Treatment (%) and Total Discharged (N)*

Treatment Level	FY05		FY06		FY07	
	%	N	%	N	%	N
SA Detox. Hospital	82.8	2,902	84.0	3,369	81.7	3,318
SA Detox. Residential	77.7	10,937	76.6	9,505	77.4	9,079
Rehab. Res. Hospital	67.0	1,553	74.0	1,644	75.8	1,703
Rehab. Res. Sort Term	83.9	2,674	82.1	2,414	81.8	2,385
Residential Long-Term	62.8	2,999	61.2	3,111	65.8	2,873
Intensive Outpatient	55.3	2,938	47.9	2,941	51.0	2,821
Outpatient	47.7	10,936	45.5	11,209	51.0	9,645
Ambulatory Detox.	80.1	870	84.3	857	85.4	714
All	**66.3**	**35,809**	**64.4**	**35,050**	**67.6**	**32,538**

* Total discharges with matching admission data

Source of Data: DMHAS

In total, about two-thirds of those who entered treatment completed their level of care. Completion rates vary widely by level of care and are higher for residential than outpatient programs. Rates were highest (80 to 85 percent) for two types of detoxification programs (hospital and ambulatory) and short-term residential care. Both outpatient and intensive outpatient levels of care had the lowest rates of completion (45 to 55 percent) .

Completion rates for methadone maintenance programs were provided for a different three-year period (FYs 06- 08). As shown in Table V-2, they are comparable to the outpatient program rates and range from around 52 percent in FY 06 and FY 07, to 59 percent in FY 08.

Table V-2. Connecticut Methadone Maintenance Treatment Completion Rates: Percent Completing Treatment (%) and Total Discharged (N)*

Treatment Level	FY06		FY07		FY08	
	%	N	%	N	%	N
Methadone Maintenance	52.9	4,227	52.0	4,212	59.1	4,263

* Total discharges with matching admission data

Source of Data: DMHAS

Results on six National Outcome Measures are presented for FY 05 through FY 07 for Connecticut's substance abuse treatment system overall and by level of care in Table V-3. (These data, however, exclude all methadone maintenance and inpatient and residential detoxification clients.) In each case, the outcome measure represents the portion of clients with an improved status between admission and discharge. Measures are only calculated where appropriate data exist at both admission and discharge.

The measures provide only a gross sense of the effects of the state's substance abuse treatment system for a number of reasons. In general, they only capture immediate effects of a level of care at time of discharge. They do not reflect long-term impact or the cumulative effect of a complete treatment episode (i.e., total exposure to services when multiple levels of care are connected to meet client needs). In addition, these measures are based on all discharges, whether or not treatment was completed.

Finally, the way some measures are calculated limits their usefulness in indicating treatment effect. For example, the employment measure is only calculated for employed or unemployed at admission or discharge (those reported as not in the labor force, which tends to be a large category, are excluded). Regarding the criminal justice involvement measure, improvement is calculated only when: those who had been arrested in the 30 days prior to admission were not arrested in the 30 days prior to discharge. In general, at least 90 of those discharged had not been arrested within 30 days of admission, leaving a very small base number for the calculation. Similarly, for the social support measure, improvement is calculated only for those reporting having "no supports" at admission and are "supported" at discharge; all those reporting "not applicable" at admission are excluded.

Given these many limitations, analysis of the measures mainly leads to more questions than insights. It is important to note the NOMs system is still under development by the federal government; current measures really are prototypes for a more extensive reporting process that

Table V-3. Connecticut National Outcome Measures by Level of Care: Percent with Improved Status (%) and Total Discharged (N)						
	FY 05		FY 06		FY 07	
Employment Status	**%**	**N**	**%**	**N**	**%**	**N**
ALL	**6.6**	**9,919**	**7.0**	**9,984**	**9.4**	**10,188**
Rehab Res Hospital	1.7	1,169	0.8	1,308	1.1	1,339
Rehab Res ST	1.0	502	1.8	381	0.5	613
Res LT	15.1	636	11.8	756	13.7	713
IOP	4.3	1,363	5.4	1,454	7.6	1,561
OP	8.0	5,906	8.7	5,851	12.3	5,775
Ambulatory Detox	2.0	343	0.9	234	4.8	187
Living Situation	**%**	**N**	**%**	**N**	**%**	**N**
ALL	**15.1**	**17,006**	**15.8**	**16,430**	**14.6**	**15,834**
Rehab Res Hospital	20.5	1,251	22.8	1353	22.0	1368
Rehab Res ST	17.6	2,465	23.1	2125	22.0	2108
Res LT	36.8	2,141	40.9	1953	32.2	1701
IOP	9.5	2,309	7.1	2505	12.9	2425
OP	9.1	7,917	8.7	7656	8.3	7567
Ambulatory Detox	16.5	842	17.8	838	8.4	665
CJ Involvement	**%**	**N**	**%**	**N**	**%**	**N**
ALL	**6.9**	**21,154**	**6.5**	**21,758**	**6.7**	**19,685**
Rehab Res Hospital	8.9	1,323	6.8	1,502	9.9	1,531
Rehab Res ST	10.3	2,653	12.5	2,413	10.5	2,385
Res LT	9.0	2,978	7.9	3,104	6.9	2,865
IOP	6.4	2,918	7.1	2,939	7.0	2,821
OP	5.3	10,423	4.7	10,943	5.0	9,369
Ambulatory Detox	5.6	859	5.3	857	6.7	714
Alcohol Use: Abstinent	**%**	**N**	**%**	**N**	**%**	**N**
ALL	**35.6**	**12,309**	**33.1**	**11,528**	**29.6**	**11,166**
Rehab Res Hospital		710		695		766
Rehab Res ST	44.1	1,572	45.0	1,300	49.8	1,292
Res LT	39.9	1,675	38.1	1,610	25.4	1,488
IOP	45.2	1,785	42.6	1,722	38.9	1,545
OP	34.2	6,356	30.4	5,954	27.9	5,788
Ambulatory Detox	19.0	211	29.6	247	22.0	287
Drug Use: Abstinent	**%**	**N**	**%**	**N**	**%**	**N**
ALL	**27.6**	**14,465**	**25.9**	**14,651**	**23.7**	**14,030**
Rehab Res Hospital		1,116		1,220		1,293
Rehab Res ST	44.2	2,089	45.8	1,750	45.4	1,699
Res LT	34.0	2,371	33.7	2,533	25.7	2,274
IOP	36.0	2,242	34.5	2,286	30.4	2,180
OP	22.1	5,914	19.3	6,126	18.8	6,008
Ambulatory Detox	20.6	733	22.4	736	30.0	574
Social Support	**%**	**N**	**%**	**N**	**%**	**N**
ALL	**32.8**	**16,105**	**33.1**	**17,227**	**35.1**	**17,291**
Rehab Res Hospital	61.8	993	66.0	1,345	65.2	1,231
Rehab Res ST	55.2	2,536	57.2	2,276	60.6	2,247
Res LT	34.2	2,466	41.8	2,803	45.4	2,619
IOP	26.2	1,847	21.0	2,306	27.0	2,579
OP	23.8	7,470	21.8	7,782	22.7	7,955
Ambulatory Detox	21.2	793	20.6	802	34.2	626
Source of Data: DMHAS						

will provide better feedback on treatment effectiveness. For example, data collection methods still vary by state, making comparisons of outcome measures unreliable. For similar reasons, SAMHSA has not established any benchmarks for state performance on the measures.

The information included in Table V-3 is presented primarily to indicate the type of outcome data being gathered about substance abuse treatment, and their potential use in evaluating what types of programs and services help what types of clients get better. With continued refinement, the measures are what PRI believes DMHAS should be tracking in order to report about effectiveness of the state's substance abuse treatment system.

Overall, Table V-3 shows the employment and criminal justice measures for all discharges had the lowest levels of improvement (6.5 to 7 percent, except for improved employment status, which was just over 9 percent for FY 07). Improvement in the measures for social supports and living arrangements were, respectively, around 33 percent and 15 percent each year.

About one-third of discharged clients showed improvement in the alcohol abstinent measure, and around one-quarter in the drug abstinent measure, for each year. Improvement is calculated for those who used at admission and were abstinent at discharge. The rates also reflect clients who did not complete treatment as well as those who did.

The department did not provide any NOMs information for the methadone maintenance level of care. According to DMHAS, this is primarily because of the long length of time between admission and discharge (typical time in methadone maintenance treatment is over one year). DMHAS is planning to develop additional measures and collect outcome data at intervals prior to discharge to provide feedback on the more immediate impact of this treatment level. However, the lack of information about results of this important level of care is problematic for several reasons.

Decades of research on methadone show it is one of the most cost and clinically effective methods of treating addiction to heroin. As heroin use is a major problem in Connecticut, methadone maintenance is a critical component of the continuum of care, serving a large number of clients every year (over 12,500 in FY 08). Despite the scientific evidence, there still is stigma and controversy associated with methadone and other opioid replacement treatments. In addition, testimony at the PRI committee's October 2008 public hearing raised concerns about the adequacy of department oversight of the program providers.

Better information on both provider compliance and methadone treatment effectiveness could increase public confidence and acceptance. The department needs to give special attention to compiling and reporting outcomes for methadone maintenance and other opioid replacement therapies. It should at least be tracking and reporting on how long people remain in the program, whether they receive required counseling, and what, if any, if any improvement they experience in their quality of life because of the treatment they receive.

Provider performance report and profiles. The department generates and reviews a substantial amount of information on individual treatment provider performance and outcomes through its extensive provider accountability monitoring process. For example, all DMHAS

human service grant contracts contain performance outcome measures. In general, the contract outcomes are a combination of expectations about service delivery and some NOMs and department provider measures listed above.

Contract outcome measures for DMHAS substance abuse providers vary for different types of service but typically include standards regarding: utilization rates; service intensity standards (e.g., number of contacts and hours of face-to-face service); treatment completion rates;[44] and customer satisfaction (e.g., positive consumer survey results). Most also contain goals regarding the portion of clients showing improvement in: substance use; living arrangements; employment status; and functioning level. Some newer contracts also contain outcome measures related to readmission and criminal justice involvement.

The performance and outcome data developed from the substance abuse provider contracts is not aggregated in any systematic way. As a result, this information cannot be used to identify programs, services, or practices within the provider network that appear more effective or to compare outcomes across providers. DMHAS does use the information to evaluate and monitor individual performance; at times, contract compliance information like residential program utilization rates is reviewed to assess system gaps and access issues.

Similarly, little of the outcome data captured in the department's provider profile and performance reports is examined beyond an individual program basis. At present, the monthly provider performance reports produced for all state funded and operated substance abuse treatment programs by the EQMI Division include: some client-based outcome measures (e.g., regarding substance use, living arrangement, employment, and functioning); treatment completion and discharge status rates; and data on retention and length of stay. The semi-annual performance profiles of GABHP providers focus on two main outcome measures of treatment effectiveness: connect-to-care rates and readmission rates.

At most, these outcome measures are compared among providers within a level of care. Certain key indicators from the HCS desk analyses (e.g., utilization rates or AMA discharge rate) are compiled for all providers, by region, for general review by the division director and other managers. The information is used mainly to identify providers with unusually high or low performance statistics ("outliers").

Comparative reports. The EQMI Division also prepares monthly statewide and regional analyses of all critical incident reports that funded and operated programs must submit to DMHAS. These data are used by regional managers and the department's medical director to identify systemic issues or trends that require a comprehensive quality improvement approach (e.g., statewide training or new policy).

However, the department was unable to provide PRI staff, within the timeframe of the study, any type of "report card" on its private provider network, the state-operated treatment programs, or the state substance abuse treatment system overall. In the recent past, DMHAS has developed some prototypes for report cards based on other state and national models and reports it is in the process of refining some for future implementation.

[44] Examples of treatment completion measures include percentages of clients who complete their program, leave against medical advice (AMA), or leave with a referral to other care.

Data reliability problems within the agency information systems (noted earlier) have been one impediment to more extensive reporting on provider performance and treatment effectiveness. Once they are addressed, the EQMI division is planning to revamp its information reporting process and products. The division is part of a recently created internal work group on information quality that is examining ways to improve the usefulness of all agency reports. It is also seeking to increase consistency, eliminate duplication, and centralize and standardize source data.

Cost effectiveness. In addition, the agency has long-range plans to match expenditure and outcome data as one way to identify the cost-effective programs and services. A prototype report in development for GABHP program providers will include several cost indicators (e.g., unit cost, and average cost per person and per admission) in addition to client, length of stay, and outcome data. Better links between information on costs and services is viewed as a first step toward performance-based contracting.

Tracking cost-effectiveness is a challenge for several reasons. The department is able to monitor GABHP payments for substance abuse services easily, and in many ways, such as per client, by provider, by level of care, and over time, because that program is a claims-based system. However, since most nonprofit providers also are supported with state grant funding, it becomes complicated to determine the actual cost of the care provided to DMHAS clients. At the time of the committee study, agency fiscal staff were just beginning to develop "blended" spending data that will allow more accurate comparisons of treatment costs among providers, programs, and levels of care.

Longitudinal information. Another weakness of the agency's automated outcome information is the limited timeframe of many of the measures. The NOMs and most of the department's outcome indicators are based on data collected about clients at admission and at discharge. In general, there is limited longitudinal information about treatment outcomes, as it is difficult and expensive to gather. Upgrades planned for the department's provider and facility automated information systems, however, will allow data to be collected at different intervals and provide the agency with greater outcome monitoring capability.

Research studies. DMHAS periodically conducts and participates in formal research studies and analyses of its substance abuse treatment services, including their long-term impact on clients. Since 2000 the department has been involved in at least five projects that directly address the effectiveness of substance abuse treatment in Connecticut. Two were done in collaboration with state criminal justice agencies and the results are discussed in descriptions of CSSD and DOC quality assurance activities.

During the late 1990s and early 2000s, DMHAS participated in a federal research initiative called Treatment Outcomes and Performance Pilot Studies (TOPPS II) that provided funding for outcome studies of treatment services for two special populations of substance abuse clients: 1) adults with concurrent mental health disorders (co-occurring conditions); and 2) pregnant and parenting women in treatment.

The first study focused on assessing the prevalence of those with mental health problems within the general addiction population and the treatment experiences and outcomes of clients

with co-occurring conditions. The pregnant and/or parenting woman study evaluated the effectiveness of different treatment approaches for this special population. The results of both studies, reported in 2003, showed substance abuse treatment was positively related to subsequent improvements that clients reported in substance use, homelessness, criminal behavior, employment, and use of health and mental health services.

In 2004, DMHAS, in collaboration with the Department of Labor and Yale University, undertook a federally funded research study designed to examine the effect of substance abuse treatment on wages. Wage information for the two years before and the two years after entering treatment were examined for a study group of 3,000 adults admitted to treatment during FY 01. The main study findings were:

- On average, one year after admission to treatment, wages for all persons in the study nearly doubled; comparing the two years before to the two years after treatment admission, wages increased by 37 percent.
- Persons successfully completing treatment had greater wage gains than those who did not; completers' wages were double the earnings of noncompleters after one year and increases continued for the second year.
- The wage study confirmed previous research that shows treatment lasting 90 days or more works best. One year after entering treatment, persons with lengths of stay of at least 90 days had earnings 150 percent greater than those with treatment stays of less than 90 days.
- Two years after entering treatment, persons who received vocational or educational services while in treatment had more than twice the percentage increase in earnings (263 percent vs. 115 percent) as those who did not receive such services.

From time to time, DMHAS will use internal staff resources to examine the impact of various initiatives. In 2007, department staff, with the assistance of the agency's ASO, conducted a review of the accomplishments of the agency's first Access to Recovery (ATR I) program, as the SAMHSA grant funding it did not provide for an independent evaluation. Over a three-year period, the nearly $23 million program served over 18,000 unduplicated individuals with substance use disorders by providing a complement of clinical substance abuse treatment and recovery support services. About 40 percent of those receiving ATR I services had no prior history with DMHAS.

The department's analysis of ATR I client and service data showed, at time of discharge from the program, the overwhelming majority of program participants were abstinent from alcohol and drugs (87 percent) and reported no arrests, jail, or prison time (98 percent). Forty percent had an increase in employment. DMHAS also found:

- Recovery supports like housing, transportation, vocational assistance, and basic needs, provided with clinical services, appeared more effective than treatment alone in decreasing substance use.

- In general, the combination of clinical and recovery supports were predictive of better outcomes (decreases in substance use, criminal justice involvement, increases in employment, and stable housing).
- People were 1.5 times more likely to achieve positive outcomes if they received short-term housing support through ATR.

A DMHAS internal review completed in October 2008 examined the impact of the department's General Assistance Recovery Supports Program on treatment retention, as measured by connection to care. DMHAS found that 70 percent of GA RSP participants in FY 08 connected to the next level of care following inpatient treatment; in comparison, only 49 percent of individuals in the department's managed behavioral health care program (GABHP) who did not receive recovery supports continued in treatment. Further, only 11 percent of clients receiving GA RSP services dropped out of treatment after admission to inpatient care versus 25 percent of those who were not in the program.

The DMHAS Forensic Services Division (FSD) also is involved in research and evaluation of the behavioral health programs it develops and implements in collaboration with the state's criminal justice system. Several of the division's current collaborative initiatives are continuity of care programs based on national studies that demonstrate: integrated care systems for substance-involved offenders reduce recidivism; and continuing treatment post-release is critical.

According to the division, evaluations of successful continuity of care programs in other states found comprehensive drug abuse treatment in prison, coupled with treatment and aftercare following release from prison, resulted in 40 to 50 percent of offenders being drug-free one year later (compared with only 15 percent of those who were untreated). Also, only about 20 percent of offenders who completed treatment were rearrested during the first year after prison (compared to nearly 60 percent of untreated offenders), and benefits appeared to be long-lasting (continuing at least four years after release.)

The division has evaluated early results of Connecticut's two current "reach-in" programs: the Connecticut Offender Reentry Program (CORP), which serves about 60 persons annually but may be expanded during FY 09; and Transitional Case Management (TCM), which serves about 110 people a year at present but also may be expanded. As both programs are relatively new and very small, outcome findings must be considered preliminary. However, FSD staff report that: CORP participants (76) had a recidivism rate of 13 percent following discharge from the program; and TCM participants (156) had a 3.3 percent rearrest rate and a 4.6 percent reincarceration rate. Further analysis of longer term results is planned.

Two of the department's largest criminal justice collaborative programs are the drug and alcohol education diversion programs the division operates with CSSD for certain first-time offenders: Pretrial Alcohol Education System (PAES) and Pretrial Drug Education Program (PDEP). Together, the programs, which are funded primarily by participant fees, serve over 12,500 individuals a year. While based on best practices, neither has been formally evaluated. Also, data related to the programs are not reported through the DMHAS substance abuse treatment information systems (SATIS) as they are considered to provide alcohol and drug education rather than clinical treatment. Neither DMHAS nor CSSD could provide PRI staff

with performance and outcome information on the PAES and PDEP programs within the study timeframe.

Consumer survey. One additional way the department evaluates the quality of its behavioral health service system is through its annual consumer survey. DMHAS uses the survey, which is based on a national instrument, to measure client satisfaction with the mental health and substance abuse services they have received. Respondents are asked to rate their satisfaction in general and regarding each of the following areas: access[45]; quality and appropriateness; outcomes; participation in treatment; and respect from staff. The department added a Connecticut-specific area, satisfaction with recovery-oriented services, to the latest survey.

Surveys are administered through treatment providers, peers, and others. Providers can add up to five of their own questions. DMHAS publishes a report on the results, presented by provider and overall, that also is available on its website. The department issued the latest survey results in November 2008. In total, 24,188 surveys were completed; nearly equal numbers of respondents reported receiving mental health (44 percent) versus substance use disorder (45 percent) services.

In summary, DMHAS found the majority of its consumers were satisfied with the mental health and substance abuse services provided to them. In comparison to national results, Connecticut clients reported: higher levels of satisfaction with participation in treatment, quality and appropriateness, and outcome; about the same level of general satisfaction; and somewhat lower levels of satisfaction with access.

The department also found respondents receiving substance use treatment services reported significantly higher levels of satisfaction regarding outcome and recovery services than mental health clients. Respondents receiving mental health services expressed significantly higher levels of general satisfaction as well as satisfaction with access, quality and appropriateness, and respect than substance use clients. In addition, satisfaction levels for respondents receiving substance use services differed somewhat by:

- demographics (e.g., by age, those age 35 and older had significantly higher levels of satisfaction in general, and regarding access, than did those under age 34);
- level of care (e.g., those receiving residential services reported significantly lower levels of satisfaction with access, outcome, participation in treatment, respect, and general satisfaction, than respondents receiving other types of services); and
- length of stay (e.g., respondents who received services for less than one year reported significantly higher levels of satisfaction with access than those who received care for longer times; those with lengths of stay of one to two years and more than five years expressed significantly higher levels of satisfaction with quality and appropriateness).

[45] Access, for the purposes of the consumer survey, refers only to accessibility of services once in treatment; it does not reflect any rating of waiting time for admission or availability of needed services prior to intake..

Monitoring resources. The department's Health Care Systems Division has 19 professional staff responsible for monitoring all substance abuse service providers. The HCS staff, with LMHA staff, also monitor all mental health providers funded by DMHAS, as well as the agency's contracted ASO for its managed behavioral health care and recovery supports programs. A monitoring supervisor, assisted by one staff person, oversees nine other personnel, who are organized into four small regional teams. Each team, which is headed by a regional manager, carries out all desk and field audit work for the private treatment programs operating within their assigned areas.

A second supervisor, with the assistance of four professional staff, oversees all monitoring and other contract administration functions related to the agency's GABHP and ATR programs. The remaining two HCS staff are assigned to various special projects.

As noted earlier, the director and nine professional staff of the Evaluation, Quality Management and Improvement Division support the monitoring efforts of the HCS staff, including working with the agency information technology unit to resolve data collecting and reporting issues. DMHAS fiscal and purchased services units also provide information and other assistance as needed to support the agency's quality assurance and improvement functions. Altogether, there are about 29 professional staff assigned full-time to contract compliance and program monitoring functions for the department's entire network of approximately 200 behavioral health service providers.

The department's main internal resource for planning, analysis, and research is its Office of Program Analysis and Support (OPAS). At present, OPAS is staffed by three professionals and supported by the EQMI Division, which can help develop and analyze data about the agency's service system. Most of the office's staff time is devoted to developing and updating the agency's federal block grant applications; monitoring and reporting on state compliance with federal funding requirements; facilitating the agency's regional planning and priority setting process; and preparing the department's biennial report to the legislature on substance use, abuse, and addiction programs.

OPAS has very limited capacity to conduct its own evaluations of agency programs and services. More commonly, the office, in collaboration with the department's one-person Research Division, manages studies carried out by the agency's various academic partners. The Research Division has an on-going relationship with Yale University and the University of Connecticut Health Center to conduct a wide range of behavioral health research projects. Currently, the division and OPAS also are working with Dartmouth College and Brandeis University on several federally funded studies of substance abuse treatment issues.

At this time, results from the department's many research and evaluation activities are not compiled in a central location and there is no unit or group of staff dedicated to promoting best practices and systemwide quality improvement. Periodically, the agency does produce, and make available on its website, one-page summaries called "Info Briefs" that describe programs and initiatives that have had positive results.

DMHAS also provides grant funding to a local nonprofit agency (Wheeler Clinic) to maintain a web-based statewide library and resource center on substance use and mental health

disorders for professionals, consumers, and the general public. Known as the Connecticut Clearinghouse, the website provides links to research and statistics on a variety of topics including national information on model programs and evidence-based practices, local training opportunities, and treatment service locations in Connecticut and throughout the country. The clearinghouse, however, is not required to identify or maintain information on best practices and effective programs and services currently in use by DMHAS funded or operated treatment programs.

Data systems. DMHAS uses an automated information system called DPAS to collect and store data from all of its funded mental health and substance abuse service providers. Aside from some demographic information about clients, this system captures basic data on types and amounts of behavioral health services provided. The agency maintains a separate information system for client and service data for the facilities and programs it directly operates called BHIS.

Additional information that includes a variety of treatment need and outcome data is gathered from all alcohol and drug abuse treatment programs in Connecticut, primarily to meet federal reporting requirements, and is maintained in a subsystem to DPAS called SATIS. All state-operated addiction service programs and all private substance abuse clinical treatment providers licensed by the Department of Public Health (which includes all programs funded by DMHAS), are required to report the required client-level data to SATIS upon admission and discharge.

At present, the system collects information from all licensed providers in the state. Providers can submit their data directly to the department through a web-based application or send DMHAS electronic files of data extracted from their own automated systems. During the summer of 2008, DPAS/SATIS was made a web-based system, which allowed for internet availability of many types of management and performance reports. However, this also led to data access issues for a number of private providers, as well as the Department of Correction. As a result, the system does not contain complete information on the state service system.

The department anticipated the new reports based on the SATIS data would provide useful feedback for providers on strengths and areas in need of improvement. However, it appears that, at least for larger providers with their own automated systems, this management and performance information duplicates what they already produce. PRI staff also were made aware of several cases where the DMHAS reports contained incorrect and/or incomplete information on provider programs. Department staff provided technical assistance to help address these difficulties.

Data quality has been an ongoing issue for the agency's provider information system and became a major focus for EQMI staff starting three years ago. After finding extensive problems with missing and incorrect client and service information, the division initiated in-depth reviews of each provider's data, followed by on-site visits to discuss and implement corrective action in the fall of 2005. Bimonthly data quality calls to address problems also were conducted. The division completed this project in July 2008. It is now developing an enhanced data tracking system to monitor submissions and flag problems that should be in place by the end of 2008.

The review process revealed a wide range of data quality issues such as: not providing data at all; large amounts of missing data; client duplication; and clients not appropriately discharged. Approximately five substance abuse treatment providers (5 percent) still have serious data problems. EQMI staff are conducting on-going, focused teleconferences with these providers that detail required action steps and timelines for completion. This effort is expected to be completed early in 2009.

The division also is addressing the data integrity issue by developing training for providers on the most common data reporting issues. According to the EQMI director, this training also will serve as a "primer" on how the SATIS data are used by DMHAS for quality assurance and improvement and how providers can use it for those purposes. Additionally, modifications are being made to the agency's automated data systems to reduce reporting errors and poor quality data. The upgrade to both department information systems (DPAS and BHIS) are planned; both improved systems should be in place by the spring of 2010.

A separate automated database for the General Assistance Behavioral Health Program is maintained by the program's ASO. The managed care system data tend to be more reliable than the agency's other client and service information, in part because they are claims-based (giving providers a strong incentive to submit complete, accurate, and timely reports.) As noted earlier, this system also is capable of producing any number of routine and ad hoc reports on the number and types of clients and services provided by location, level of care, and cost.

To date, the department has used the GABHP information system to focus on examining patterns and trends within the highest (and most expensive) levels of care (i.e., inpatient and intensive residential services), although other levels also have been reviewed. At present, DMHAS is working to develop management reports that will contain performance measures and cost information by providers within care levels.

Current GABHP provider profiles that contain several key performance and outcome indicators are generated two times a year. They are used by the HCS staff to monitor the agency-funded treatment programs and also are sent to providers. The reports the providers receive allow them to compare their performance to the statewide average and other provider programs with the same level of care, although no identifying information is included.

Judicial Branch Court Support Services Division: Judicial Branch

As discussed earlier in Chapter III, staff of the Judicial Branch Court Support Services Division administer assessments to assist in determining treatment needs for division clients and develop case plans to address the most pressing criminogenic needs. However, CSSD contracts for all substance abuse treatment services client require; division staff do not provide direct clinical care.

The division has a formal contract monitoring process in place to ensure the quality of its contracted treatment services. It also has research and quality improvement units that perform data collection, research, and evaluation activities related to all programs and services provided to CSSD clients. These efforts are described below.

Monitoring and quality assurance. Contract oversight is a key part of the CSSD overall quality assurance system. At the time of the committee study, this system was being revised and a new process was being phased in. The main features of the division's present process include the following elements.

- CSSD classifies its contracts into one of three levels for monitoring purposes according to specific criteria spelled out in division policy. The level determines the intensity of monitoring that is performed.

- Level one contracts are essentially for those programs that are certified or licensed by another authority, such as DPH, or their quality is assured by another entity.

- Nearly three-quarters of CSSD's 190 contracts are classified as level one. At a minimum for a level one contract, CSSD staff :
  - analyze providers' monthly statistical management reports;
  - conduct an annual stakeholder meeting for certain programs and analyze satisfaction surveys completed by stakeholders;
  - conduct at least one visit per year at each program delivery location; and
  - complete an annual written report that documents the analysis of that information.

- Site visit activities include inspecting the physical plant and facilities, checking that contractual requirements are being met, verifying the case management process, observing program interaction with clients, seeking feedback from clients, and verifying certain policies and procedures are in place.

- CSSD's residential substance abuse treatment programs are all provided through a collaborative contract process with DMHAS. DMHAS is responsible for the monitoring and quality of these programs.

- CSSD outpatient programs are licensed by the Department of Public Health, the contracts for all theses programs are classified as level one contracts.

- Level two contract monitoring is similar to level one, but level two contract sites receive at least receive four quality assurance visits per year and require staff to complete at least two quality assurance reports per year

- At the highest end of the spectrum are level three contracts that are in whole or in part research- or evidence-based programs.

- About 5 percent of CSSD's contracts are classified at level three. Nineteen of the level one and two contracts also receive this additional monitoring.
- Currently, the monitoring policy, issued in 2005, calls for CSSD staff to perform "group quality process assessments" of all level three programs. The group quality assessment process requires the review of various aspects of the program including judgments about the program staff's facilitation skills and group facilitation process.
- The policy also calls for these assessments to check each program's fidelity to individual models.
- CSSD staff have acknowledged that program fidelity checks have not been fully implemented given that the contract staff does not have the capability to assess program fidelity.

If any problems are noted at any level of review, a corrective action plan (CAP) with expected dates of completion is developed in consultation with the provider. Typical problems usually involve timeliness of reporting and performing intakes, appropriate referrals not being made, and reallocation of budget items without approval. Last year 226 corrective action plans were developed. Corrective action plans vary in severity and complexity. Depending on the issue(s) to be addressed the time taken to resolve these issues varies. The CAP issues are not aggregated or compiled into an annual summary.

One recent initiative begun in 2006 applies rigorous quality assurance, including program fidelity checks, to three of CSSD's contracted programs - Adult Incarceration Centers (AIC), Adult Risk Reduction Centers (ARRC), and the Striving Towards Achievement, Renewal and Success (STARS) program.[46]

This quality assurance initiative includes assessing the degree of accuracy with which services are being performed as well as improving staff skills through coaching, training, and positive reinforcement.

Currently, only the AICs, which provide several services (including a substance abuse program called Treating Alcohol Dependence) have any quality assurance outcome data. The TAD quality assurance reports measure fidelity and integrity by which the curriculum is delivered. A process is in place to address low end performers.

There is no formal quality assurance process around the work of probation officers. However, CSSD has developed a fairly comprehensive risk reduction model for probationer supervision that identifies core practices as well as processes and tools to implement the practices to guide probation officers and supervisors in doing their work. The policy is being implemented in December 2008. While the procedures to implement the model are not a formal

[46] AICs provide monitoring, supervision, and programming during the day and evening in a structured, center-based setting. AARCs are for probationers who are high risk and have high treatment needs. STARS is a program with developmentally appropriate, gender responsive services, and education programming designed for females, ages 16-21.

quality assurance process, it is designed to allow the staff to implement the risk reduction model with integrity and fidelity.

Selected best practices. CSSD has adopted or is experimenting with many of the selected best practices included in the scope of the committee study. Current efforts are highlighted below.

Substance use testing. The frequency of substance use testing for CSSD clients varies. CSSD clients may be tested by probation and/or programs as part of a court order or condition of probation. CSSD is not able to connect substance use test data with an individual's time in substance abuse treatment. The division does maintain data for those on probation subject to substance use testing. For 2007, 35,665 drug tests were performed on 14,386 probationers. Just over 7,000 probationers failed a drug test at least once, and about 3,000 failed more than once. Probation officers implement graduated sanctions when clients have positive urinalysis results.

Evidence- or research-based practices. For substance abuse treatment providers, the division requires the use of an evidence or research-based assessment tool. As previously discussed, the division uses validated assessment tools (Level of Services Index and the Adult Substance Use Survey) to perform its assessments. The division also requires the substance abuse treatment programs be evidence or research-based programs. Part of the core practices for probation officers involves training in motivational interviewing techniques that assists probation officers in judging and enhancing a probationer's motivation to identify problem areas he or she want to work on and improve. The therapeutic alliance is measured for those probationers in the AICs through a validated instrument called the Working Alliance Inventory. The therapeutic alliance is not currently measured for those in other substance abuse treatment programs.

Discharge planning and aftercare. All treatment providers are required through DPH regulation to provide a discharge plan to those receiving substance abuse treatment upon discharge. Discharge reports are also required by contract and are reviewed by a Compliance Specialist during the CSSD audit process.

External credentialing. All substance abuse treatment facilities must be licensed by DPH. With the exception of one Adult Behavioral Health provider, all CSSD providers are licensed by DPH. CSSD does not require any other credentialing of substance abuse treatment providers or employees than what is required under DPH regulation.

Outcome and performance measures. CSSD does not currently collect any system wide performance or outcome data on its clients involved in substance abuse treatment programs. Program review staff could only obtain completion rates for the substance abuse treatment programs provided at CSSD's Adult Incarceration Centers, which was 50 percent since January 2008.

Improvements in the outcome and performance data are expected with the implementation of a new contractor data system, described below. It should be noted that individual probation officers know how well each probationer assigned to them is progressing because of regular reporting requirements of probationers based on level of risk. The focus here

is on what is known and tracked regarding system-wide performance for overall management purposes.

To date only one study, conducted by DMHAS in collaboration with CSSD, has been completed that directly addresses substance abuse treatment for CSSD's clients. The "Substance Abuse Need for Treatment Among Probationers" was a study published in 2005 and conducted by Yale University's School of Medicine. The study did not focus on treatment outcomes, however. The purpose of the study was to determine the substance use activities, co-occurring conditions, treatment barriers, and the motivation and access to treatment among active probationers. The study found:

- forty-eight percent of probationers had a current substance use disorder, but two out of three (66 percent) of those needing treatment were not receiving care;
- forty-five percent of probationers were found to have a positive urine screen, mostly for marijuana and cocaine;
- barriers to treatment included: denial; probationers thinking they could handle the problem themselves; lack of resources; stigma; and lack of space at a treatment facility;
- of those motivated for treatment, 33 percent had not received treatment in the past year; and
- forty-three percent of those currently needing treatment also were identified as probably having depression.

The division is currently working on several projects that focus on the outcomes of the division's various assessment and treatment activities. This includes a recidivism analysis that will track cohorts of adult and juvenile offenders by risk level for up to three years post-treatment. In addition, the division is examining the collection of information regarding treatment completion rates and employment status gains.

Except for some information required by the DMHAS collaborative contract for residential providers, DMHAS has not made any of the performance or outcome information that it collects from programs that provide services to CSSD clients available to CSSD. In addition, the division maintains its own database for residential services from which it monitors daily counts and outcomes and can analyze rates and trends.

Monitoring resources. CSSD's grants and contracts unit has 12 people who are responsible for ensuring that 190 contracts adhere to contractual requirements as outlined above. The adult services contracts totaled about $47.5 million in FY 2008.

CSSD also has a robust internal research capacity. The division created both the Center for Best Practices and the Center for Research, Program Analysis, and Quality Improvement in 2005. The Center for Best Practices has nine professional staff and the Center for Research, Program Analysis, and Quality Improvement has eight staff. Together these units assist the division in incorporating research-based principles into agency practice and in developing

outcome and evaluation data about programs and operations. CSSD also has employed four full time consultants to assist in various technical activities, from determining how to extract data from existing databases to developing data sets and reports for operational and research purposes.

Over the last several years, the division also has initiated a number of research projects that evaluate some of its programs and assessment tools in partnership with several academic institutions. This includes an evaluation of the Probation Transition Program and the Technical Violations Unit, a validation of its Bail Decision Aid, and an evaluation of the Building Bridges Prisoner Re-entry programs.

Data systems. CSSD uses a client management information system (CMIS) to collect and store data for both juvenile and adult offenders. Aside from demographic information, the system maintains information on:

- arrests;
- the bail point scale for release recommendations;
- court-ordered and probation officer-required conditions;
- presentence investigation reports;
- violation activity and drug test results;
- evaluation and mediation of family civil cases assessments for court release; and
- pretrial status for family criminal matters.

CMIS also links to the adult court system and the state's offender based tracking system. The division provides limited access to some CMIS information to the Board of Pardons and Paroles and municipalities. CSSD does not have access to DMHAS' Substance Abuse Treatment Information System (SATIS) nor to the substance abuse treatment information maintained by DOC.

CSSD is in the process of piloting a new Contractor Data Collection System (CDCS), which is a web-based "quality improvement tool that obtains key measures of treatment data on individual clients within CSSD's network of contract services."

- Providers will be required to enter a range of data about client services directly into CSSD's system. These data elements include: demographic information, referral date, intake date, assessment information, date and type of services information, pre- and post-test scores, service discharge dates and reasons, referral to community based services, and program discharge dates and reasons.

- Once enough data have been entered, CSSD will be able to gauge the current performance of its provider network. As the information is analyzed, CSSD will begin to identify ways to improve the delivery of treatment services.

- The system is being phased in. Currently, all of the 17 Adult Incarceration Centers, six of the 42 adult behavioral health sites, and a youth program are using the system. Because of its recent implementation, no trend information is available at this time nor have performance benchmarks been identified. CSSD will begin to identify performance benchmarks after enough data have been collected about the current system.

Department of Correction: Facility-Based Treatment Programs

As described in Chapter IV, all correctional facility-based treatment programs are delivered by DOC employees through the agency's Addiction Services Unit (ASU); there is no need for any external contract compliance process. ASU performs its own internal program audit process on an annual basis and engages in several other best practices.

Monitoring and quality assurance. The ASU program standards are based on the National Institute of Drug Abuse's Principles of Addiction Treatment for each of its treatment programs that are checked through an in-house program audit process. Each program is audited once per year through the use of an internal peer review team. The focus of the audit is on:

- program fidelity through direct observation of counselors;
- program quantity;
- case management and documentation process;
- counselor utilization and professional development; and
- program environment.

ASU audits result in Corrective Actions Plans (CAP) to address deficiencies for each program such as file documentation, clinical supervision, and environmental needs. Corrective actions are usually issued for every program. Time frames are included in the CAP and issues are worked on throughout the year and assessed in the following annual audit. ASU does not annually compile any summary report on problem areas.

In addition to the annual audit, each addiction services counselor supervisor is required to submit monthly statistical reports to the DOC central office for programs they oversee. These reports include the following:

- various specific statistics on each treatment program offered (e.g., admissions, discharges, and urine screens);
- monthly narrative reports about five areas: 1) Major Projects and Special Events, 2) Goals and Objectives, 3) Major Issues, 4) Developments and Corrective Action, and 5) Statistical Summary;
- inmate tracking reports that are a check/balance for the statistical report. These reports provide the name, Criminal Justice Information System number of the offender admitted, and reason for discharge. This report also identifies offenders who have dependent children under the age of 17, and the child's

birth year. This information is an important part of DOC's quarterly and FY report on TANF funding;

- clinical supervision monthly logs; and
- individual counselor training reports (i.e., professional development).

Other quality assurance initiatives. The ASU has a quality assurance process for the health services provided through its contract with the University of Connecticut. The quality assurance for the ASU consists of the program monitoring activities discussed above.

Selected best practices. ASU engages in a number of best practices to improve treatment outcomes. Current efforts are summarized below.

Substance use testing. DOC regularly checks for substance use. For those inmates enrolled in ASU treatment programs, DOC tests 20 percent of current program participants monthly. In 2007, about 2,239 urine screens were performed on inmates enrolled in ASU treatment programs while in a DOC facility. Of those, 29 (1.3 percent) turned up positive. The department has a graduated sanctions policy for those inmates who have a positive urine screen while in treatment. Relapse into active substance use is viewed as a treatment issue for the addiction services unit.

For inmates who are being treated while on transitional supervision (i.e., a form of early release), 879 screens were performed and nearly 40 percent were positive. These urine screens administered during FY 07 show that DOC community staff screened 60 percent of the offenders receiving treatment. DOC believes that the rate of positive findings is indicative of an observant clinical staff who can recognize a person in need of help because it is beneficial to identify those in need of more intense levels of treatment, supervision, and if necessary re-incarceration to a structured environment (e.g.,. Technical Violator Program). An inmate on transitional supervision that receives a positive drug screen while in treatment are seen in a case conference that involves the parole officer, the ASU counselor, and the client. During this conference the offender's behavior is assessed, and an appropriate clinical or custodial response is developed in the form of a case conference contract, which is similar to a treatment plan in that it identifies the problem, establishes goals, methods and objectives, and is evaluated/reviewed as needed, usually on a weekly or bi-weekly basis.

Evidence- or research-based practices. As noted in Chapter IV, nearly all inmates are screened and assessed for substance abuse needs through two standardized instruments – Texas Christian University Drug Screen II and Addiction Severity Index (ASI). Both are evidence-based tools but the ASI is not validated for a prison population. The treatment programs are evidence-based excerpt the Tier 1 program.

The therapeutic bond between counselors and participants is not formally measured at DOC. However, random samples of inmate participants from each program are interviewed by an auditor during the annual audit. Clinical reviews of counselors occur on a regular basis, ranging from weekly to quarterly, based on the experience of the counselor and according to clinical supervision standards. All new ASU counselors are trained in motivational interviewing (MI), which is offered regularly to current counselors through the ASU in-service and annual

monthly training sessions. The total number of counselors trained in MI could not be readily determined.

Discharge planning and aftercare. Aftercare is available in most DOC facilities and is offered to anyone who has completed a Tier 2 or higher program. Aftercare sessions are co-facilitated by addiction services staff and inmate participants, consisting of three open group sessions per week for a total of 30 sessions over 10 weeks. Alcoholics and Narcotic Anonymous Fellowship meetings are provided at all DOC facilities. These meetings are provided by a network of volunteers. Both programs help to support treatment efforts by reinforcing recovery attitudes and practices. If an offender is eligible for early release, other supports may be identified at time of parole through the Parole and Community Services Division.

External credentialing. As noted, the Department of Public Health is responsible for the licensing of substance abuse treatment programs in the state. The Department of Correction as a state agency is exempt from licensing. All alcohol and drug supervisors and counselors who deliver substance abuse treatment in DOC programs are certified or licensed by DPH as required by PA 02-75.

Outcome and performance measures. There are no performance or outcome measures established for DOC treatment programs, such as expected admission or completion rates or percentage of clients who remain abstinent or reduce use after discharge from DOC custody.

Program review staff found that completion rates for DOC facility-based programs were between 35 percent and 75 percent depending on the level and/or intensity of the treatment program in 2007. The completion rate for offenders on transitional supervision was between 15 and 45 percent. Part of this low completion rate for facility-based programs can be explained by the movement of inmates due to security concerns (the exact number is not readily available). The department points out that the mission of the Department of Correction is primarily to provide safety and security and this often means that inmate movement to support that mission takes precedence over concerns such as program placement. The department contends that systems are in place to track program participation and are used to limit movement in order to maintain program enrollment when possible, though the department could not identify the number of inmates who had to drop out of programs because of safety and security concerns.

DOC is considering adopting a performance-based measuring system for substance abuse treatment services that has been developed by the national state association of correctional administrators. Among the indicators this system monitors are: number of inmates released who received a substance abuse assessment during incarceration compared to total number of inmates released, and number of inmates enrolled in treatment and number that competed treatment compared to those diagnosed with a substance use disorder that were released without any treatment.

Studies of DOC treatment programs have been conducted that examine treatment outcomes and recidivism. All have found a positive relationship between substance abuse treatment and recidivism. Three of these studies are described below.

In 2006, the DOC, the Department of Public Safety, and DMHAS conducted a study to determine the effects of treatment on correctional inmates with a history of substance abuse problems. The study included sentenced inmates who were released in FY 2003 and included those released for time served or placed in transitional supervision or in a halfway house. Primarily, the study investigated the rate of re-incarceration and re-arrest of this population in the two years following release from prison.

- Inmates who successfully completed in-prison substance abuse treatment had a lower rate of re-incarceration (39.3 percent) than inmates not completing treatment (45.3 percent).
- Overall, those who received treatment had a lower rate of re-incarceration than those not receiving treatment within five months of being released. The same held true for re-arrest rates.
- When controlling for all risks for re-arrest, receiving treatment significantly increased the length of time to felony re-arrest across all treatment groups when compared to those not receiving treatment

An evaluation of DOC's treatment structure (i.e., the four tiers described in Chapter IV), conducted by Brown and Brandeis Universities in 2002, found that inmates who attended the Tier programs were significantly less likely to be rearrested. The study examined three time periods of six, 12, and 18 months after release.

- Of those inmates who *participated* in Tier programming (including drop outs), 32.5 percent were re-arrested within one year compared to a rate of 45.9 percent for those who did not attend. Those inmates who actually *completed* a Tier program were even less likely to be re-arrested (29 percent compared to 43.5 percent of non-completers and 45.9 percent of non-participants). In addition, the severity of the crimes committed was also reduced.
- There was also a relationship between the level or intensity of treatment and recidivism. Tier 4 participants were re-arrested at a rate of 17 percent, Tier 3 at a rate of 20 percent, and Tier 2 at a rate of 32 percent. Tier 1 had virtually no effect on recidivism when controlling for other variables and could be related to higher recidivism.
- The same study indicated that the cost effectiveness ratio for Tier program participants ranged from 1.8 to 5.7 for all participants. The only benefits included in this analysis were the avoided costs for re-incarceration and not other societal benefits that may result in a lower crime rate.

Changes have been made to the Tier 1 and Tier 3 programs since the publication of this 2002 study. Although the 2006 study mentioned above is suggestive of the positive affects of the changes, it did not specifically examine the various effects of different Tiers.

Finally, a 1996 study of the Marilyn Baker House, a residential therapeutic program for women, by researchers from Central Connecticut State University, suggested that the inmates who completed the program were the least likely to recidivate.

Monitoring resources. The program monitoring described above is completed by in-house staff who have other job responsibilities in addition to performing the program audits. The audit is a peer review process and is composed of counselors who normally provide direct services to clients or perform administrative duties. The audit teams consist of licensed or certified correctional counselor supervisors and correctional substance abuse counselors, and each team is managed by a correctional counselor supervisor. Staff are assigned to audit teams in accordance with their specific knowledge of the programs they will audit. Each team has a range of three to six members. Each program audit is scheduled to take three days annually, per site.

Program evaluation beyond internal audit and clinical supervision is limited. Any internal research is ad hoc and no individuals are dedicated to this function. There have been a few studies conducted by external consultants over the last several years examining outcomes as described above. Several more studies are being developed that tend to focus on populations with specific disorders that may be associated with substance abuse, such as psychiatric disorders and HIV-infected individuals. These studies will not be evaluations of DOC substance abuse treatment programs.

Data systems. DOC staff report that the information technology systems they access are dated or have serious technical issues and appear to impede meaningful research. The ASU uses three databases to collect substance abuse treatment information.

- ***RT3M Program Tracking Management System***. This is an agency-based system designed to allow the department to record information about inmate participation in programs. For example, it: provides information regarding how many inmates are participating in programs; can assist in determining how many staff are needed; identifies the amount of programming specific staff are providing; can be used to study recidivism; and can be used to review classification decisions.

- ***Addiction Services Monthly Statistics Report***. This is an Excel-based data collection tool developed by ASU to track a myriad of statistical data specific to ASU staff, community programs, and information specific to each service offered by ASU.

- ***DMHAS Substance Abuse Treatment Information System (SATIS)***. DOC, like other providers, is required by law to report certain substance abuse treatment data to DMHAS. ASU staff have had the ability to provide treatment information to DMHAS for a number of years. However, access to the electronic and/or computerized SATIS system has been erratic as there has been a series of technical problems since 2003. Currently, only a portion of DOC data resides in an electronic format on SATIS. The system allows DOC to obtain demographic and treatment admission and discharge history for inmates who may have participated in any state licensed alcohol or drug program that can assist in program placement decisions. However, most

client treatment information generated through SATIS by DMHAS is not shared with DOC.

Department of Correction: Parole-Based Treatment Programs

The DOC Parole and Community Services Division (parole division) is responsible for supervising and providing support services to all offenders released on parole by the Board of Pardons and Paroles, or to transitional supervision by the Department of Correction. The division maintains a wide network of contracts with private non-profit community providers for residential and nonresidential supervision and treatment of offenders. Below is a summary of contract compliance and performance monitoring activities completed by the division.

Monitoring and quality assurance. The network of programs that the parole division uses includes 36 nonresidential and 49 residential providers. All levels of substance abuse treatment are available through this non-profit network. A detailed description of the types of programs available through the parole division was provided earlier in Chapter IV.

While there is not a formal quality assurance program within the parole division's contracting and monitoring process, there are a number of oversight measures the division performs.

- Parole officers receive daily information from the substance abuse treatment providers regarding individual parolee noncompliance and documentation of program completion.

- Monthly reports are also received by the division indicating the aggregate amounts of activity (e.g., number of evaluations, admissions, toxicology screens, and individual and group sessions) by provider. The information is used by division managers and individual parole officers to coordinate treatment and supervision efforts. This information is not, however, aggregated to examine overall trends or contractor performance and is output, not outcome, data.

- Twice a year, representatives of all residential and non-residential programs attend a mandatory coordination meeting sponsored by the division. These meetings allow for feedback that addresses both treatment and supervision coordination between parole staff and contracted providers.

- Compliance audits are aimed at the full range of contractor activities including admissions and intake, client services and supervision, administration, and facility concerns. However, these audits are completed on an irregular basis for residential programs and have not been performed on nonresidential programs since early 2007 because the staff person assigned was transferred to other supervisory duties. The division has revised audit procedures and

documents but reports that there are not sufficient staff resources to complete the necessary audits on residential and nonresidential programs. Some limited review of record systems is completed by parole officers assigned to residential programs. When audits are performed, two staff are selected from the ranks of parole officers who must defer other duties to complete the audits. Corrective action plans are developed when compliance issues are found.

There is no regular monitoring of treatment plan compliance by parole division staff nor any checks on treatment program fidelity. Private providers may be performing this quality assurance activity on their own, but it is not known how many do. Seventy-seven of the parole division's residential treatment beds are provided through DMHAS' collaborative contract. DMHAS is responsible for the monitoring and quality of these programs. The parole division reports that it does not receive any monitoring reports from DMHAS. Further, the parole division does not require providers to notify it if DPH has issued any violations about the provider programs.

All current residential and non-residential contracts are going to be re-bid by the parole division within the next year. As part of this process, the division is planning to incorporate assurances for program fidelity.

In addition, the division is piloting a program fidelity project that involves six residential work release programs. One of these programs provides substance abuse treatment services, though all the programs may refer a client to such services. The division hopes to implement similar procedures with other providers after the pilot period.

While supervisors conduct performance reviews of parole officers on an annual basis, there is no quality assurance process around the work of parole officers. It should be noted that the parole officers have completed extensive training to administer new assessment tools, the Level of Service Index and Adult Substance Use Survey.

Selected best practices. The DOC parole division has adopted some of the selected best practices related to substance abuse treatment for adults. Activities carried out at present are discussed below.

***Substance use testing*.** Substance use is checked for all parolees at least monthly and possibly more often depending on the risk profile of the parolee. For those receiving substance abuse treatment services, substance use is checked based on the risk severity that the parolee presents – the range is from once per month to twice per week.

It is division policy that when a parolee receiving treatment fails a substance use test, the parolee is subject to graduated sanctions, which could mean greater testing and case management up to a return to prison. The division notes that the graduated sanctions policy was suspended immediately following the Cheshire incident in 2007. The division estimates that about 7.8 percent of urine screens for those who are receiving treatment come back positive based on the results from the month of September 2008. The division could not readily determine how many separate people this represented. The division is not able to obtain this type of information from its electronic information system.

Evidence- or research-based practices. The division requires that substance abuse treatment programs be evidence- or research-based programs. These programs may or may not be validated for criminal justice populations.

Assessments may be conducted by the parole division and the treatment provider and are required to be evidence or research-based. The criminogenic needs of paroled offenders are assessed by the DOC parole division. As previously discussed, the division is implementing validated tools (Level of Services Index (LSI) and the Adult Substance Use Survey (ASUS)) to perform its assessments. The division is in the process of training parole officers in motivational interviewing.

Substance abuse providers also perform assessments on those paroled inmates referred to them for treatment. While there is no required standard instrument, the parole division requires its providers to use evidence-based assessment tools. The division reports that most providers use the Addiction Severity Index or the Adult Substance Use Survey assessment tool.

The level of treatment need is determined by the private provider, and it is assumed the assessor is factoring in any treatment obtained while the offender was incarcerated. While there are no standard treatment protocols required by the parole division, the division does require an individualized treatment plan be created. The assessor also, in most instances, is the provider of substance abuse services. The parole division does not independently check on how an offender's needs match with the intensity of services delivered.

One issue brought to program review staff's attention is that parole staff do not appear to consider substance abuse treatment received in prison when making a referral to treatment services. Parole staff have indicated that they may refer inmates, who have been assessed with an addiction, to residential treatment regardless of treatment received in prison. It appears that, in some cases, the availability of treatment slots in a more structured setting may be impacting placement criteria rather than clinical need.

It should also be noted that inmates that are released under the authority of the Board of Pardons and Paroles are evaluated by the parole board. The parole board does not perform any independent assessments of *offender needs*. The parole board does administer the Salient Factor Score (SFS), which is an assessment instrument used to examine an offender's likelihood of recidivating following release from prison. The board uses the information generated by the SFS to guide release decisions and may consider any in-facility DOC-generated assessment information to stipulate any special conditions on offenders, like substance abuse treatment. The needs of the offender are assessed by the parole division after the board has acted. The outcome of the assessment may result in additional stipulations added to the offender's release conditions.

Discharge planning and aftercare. All treatment providers are required by DPH regulation to provide a discharge plan to those receiving substance abuse treatment upon discharge. According to the parole division, each residential and nonresidential provider is required under contract to develop a discharge plan for each offender within 15 days of discharge. The parole division's audit requirements call for this contract provision to be checked.

External credentialing. The parole division does not require any formal credentialing of its substance abuse treatment program contractors. The division reports that one of its contractors is not licensed by DPH. Substance abuse treatment providers (i.e., clinicians and counselors) are not required to be licensed or credentialed under the parole division's contracts though the division encourages them to be licensed by awarding credit in the RFP process for those bidders that have licensed treatment providers.

Outcome and performance measures. The parole division developed performance measures for private nonprofit contractors in the mid-to late 1990s. Currently, there is no monitoring or review of these performance measures. It is not known what overall completion rates are for the division's various programs. No provider's contract have been suspended or terminated because of poor performance in terms of these measures.

Two studies over the last several years have concluded that community supervision and the services offered through the parole division had a positive impact on recidivism. One such study -- the 2006 collaboration between DOC, the Department of Public Safety, and DMHAS -- found persons released to halfway houses and receiving treatment were 42 percent less likely to return to prison within two years of release and 37.4 percent less likely to be re-arrested than those released to halfway houses but not receiving treatment.

Further, the second annual recidivism study (2008) published by the Office of Policy and Management's Criminal Justice Policy and Planning Division found that inmates who were released from prison with some form of community supervision were less likely to recidivate. The 2008 report, which assesses recidivism rates of offenders released during the 2004 calendar year, made these findings:

- Offenders with the highest success rates and least likely to recidivate were those under DOC community supervision. The study defined early release through parole in two ways – community release and transitional supervision. Of those released to community programs, 67.3 percent did not recidivate. Of those released to transitional supervision, 64.5 percent did not recidivate.
- Arrest, conviction, and new prison sentence rates were higher for offenders with no post-prison supervision.

The study also found that the majority (63.5 percent) of offenders with high substance abuse need scores (i.e., assessment scores of 3 or higher) were released with some form of community supervision, which is generally considered a good practice. It further showed offenders with high substance treatment need scores did not have significantly different recidivism rates from those with low need scores. Since the study did not identify which programs or type of treatment released inmates actually participated in, it is not possible to link successful outcomes with specific treatment programs.

Monitoring resources. Within the parole division, three people are responsible for ensuring that 36 nonresidential and 49 residential providers adhere to contractual requirements as outlined above. The total value of all residential ($30,596,827) and nonresidential contracts ($6,507,122) for FY 2009 is $37,103,949.

As discussed above, DOC, including the parole division, has extremely limited internal research capacity. Any internal research is ad hoc and no individuals are dedicated to this function for the parole division. There is no best practices unit for the division.

Data systems. The parole division has a limited and outdated management information system that inhibits administrative and research capabilities. The system is a case management system based on a Lotus platform. It was a prototype obtained for free from the State of Georgia, though only approximately 15 percent of the original program was retained. Parole staff report that the system was to be upgraded in stages to meet their particular and unique needs, but funding was not sustained to ensure the necessary upgrades. Reported problems include:

- the division has limited ability to query the system to understand overall trends or to develop customized management reports about the division's activities;
- there are few standardized reports and not enough to meet the management needs of the parole division;
- it is not a user friendly system -- prototype drop down menus, for example, were developed by software designers but not field tested by the end-users and adjusted to their needs; and
- parole staff report often having to perform data collection manually or obtain information from paper files or cross-reference information with DOC's other systems to ensure accuracy.

Chapter VI

Committee Findings and Recommendations

Program review committee findings concerning the state substance abuse treatment system for adults, along with proposals to address identified deficiencies, are presented in this chapter. PRI recommendations discussed below center on issues related to three areas critical for effective treatment:

1) access to services;
2) monitoring of service quality and outcomes; and
3) comprehensive, systemwide planning, coordination, and oversight, which is the role of a strong lead agency.

From its examination of the state system, the committee found client access to substance abuse treatment is restricted by limited capacity. There is substantial unmet demand for services, particularly for residential treatment, although there are no reliable estimates of the number of adults in the state who are requesting but not receiving care.

At present, the state substance abuse treatment system for adults is decentralized and disjointed. There are gaps in the continuum of services available; uniform policies and procedures are missing in many areas of practice. A number of promising cross-agency initiatives and innovative practices are underway, but they tend to be "micro" collaborative projects, occurring on a pilot basis and limited to small target populations.

In particular, more attention must be given to coordinating treatment resources, as well as planning and monitoring efforts, to meet the special and significant substance abuse treatment needs of the criminal justice population. Monitoring of treatment quality across providers, levels of care, and funding sources is neither consistent nor comprehensive at present. A major impediment to quality assurance and quality improvement efforts is the absence of formally established performance goals and benchmarks for publicly funded treatment services.

The committee additionally found considerable amounts of outcome data and research on treatment effectiveness are produced by all three state agencies that serve adults with alcohol and drug use problems. However, this information is not aggregated, analyzed, and reported in ways to promote accountability and guide policy and funding decisions systemwide. Information sharing across state agencies and with the private provider network remains a challenge for both technical and administrative reasons.

Clearly, DMHAS, as the lead state agency, needs to take a strategic approach to statewide planning that begins with setting clearly defined, measurable goals for the treatment system. It also needs to strengthen efforts to coordinate services and practices across agencies to: address gaps and avoid duplication; promote more cost-effective delivery; and combine agency efforts to better meet client needs. Most importantly, the department must assume responsibility for continuous quality improvement throughout the treatment system; it should be regularly

reviewing the effectiveness of publicly funded treatment programs and services and determining how they can be improved.

In total, the committee made 31 recommendations requiring both legislative and administrative changes that are discussed in detail below. Overall, these recommendations are aimed at system improvements that can: expand treatment options; enhance treatment quality and service delivery; and achieve better treatment outcomes for adults with substance use disorders.

Access to Treatment

There are three aspects of accessing substance abuse treatment of concern: the demand for treatment, the length of time elapsed from identifying a need for treatment and the actual receipt of treatment, and the length of treatment. Each of these elements has an impact on the effectiveness of substance abuse treatment.

In brief, the program review committee finds that DMHAS, the lead state substance abuse agency, does not:

- *assess or estimate unmet demand for substance abuse treatment;*
- *maintain an information system on treatment availability for the public;*
- *monitor the length of time it takes to receive substance abuse assessments and treatment; or*
- *track the length of treatment that clients receive.*

Unmet demand. As discussed in Chapter I, data that compare those in need of substance abuse treatment and those receiving it (called the "treatment gap") are collected by the federal government each year through the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health. In 2006, 8.2 percent of persons 18 and over in Connecticut needed but did not receive treatment for their alcohol use disorder, and another 2.5 percent needed but did not receive treatment for illicit drug use problems. These percentages represent approximately 204,000 and 66,000 Connecticut adults, respectively.

This treatment gap is slightly larger in Connecticut than the national average (7.5 percent for alcohol and 2.3 percent for illicit drugs). The federal data do not capture the extent of the overlap among those with both alcohol and drug use problems.

The need for treatment is not the same as the demand for treatment. Assessing how many people have a substance use problem is different from determining how many people with a problem will show up for treatment services. However, DMHAS does not measure the demand for substance abuse treatment in Connecticut, making effective planning on how to best meet service needs throughout the state impossible.

Although a comprehensive picture of unmet treatment demand is not available, some examples of unmet demand can be found among the state agencies that were part of the committee's study. Specifically:

- CSSD noted that as of July 2008, there were over 480 clients waiting for residential treatment services. In 2007, there were over 4,000 referrals to residential treatment services, although only about 1,800 people received them. This means that about 2,200 people who sought a residential level of treatment did not receive it. The average wait time for nonresidential outpatient services for CSSD clients is about two to six weeks.

- A 2005 study of active probationers found 48 percent of probationers had a current substance use disorder, but two out of three (66 percent) of those needing treatment were not receiving care. About one-third of probationers with a substance use disorder cited the lack of space at a treatment facility as a barrier.

- In 2007, about 12,000 incarcerated pre-trial and sentenced inmates housed by DOC were in need of addiction treatment services and about 5,500 were admitted for treatment. About 2,400 offenders were on a wait list to receive services at the end of 2007.

- During FY 08, about 9,600 individuals who were released from DOC direct admission facilities (i.e., jail) had a verified need for substance use treatment. Only about 10 percent (1,012) of those individuals received any treatment (Tier 1 program) before their release. One factor contributing to this low percentage is that direct admission facilities generally only hold people for a short period of time.

- Similarly in FY 08, about 10,900 individuals who were released from a DOC sentenced facility (i.e., prison) were assessed with a substance use disorder and about 26 percent (2,841) received treatment. It could not be readily determined how many inmates were placed on parole and probation and received treatment post-incarceration.

- DMHAS does not collect or track wait list information from its funded providers or the programs it operates.

In interviews, DMHAS personnel `asserted that maintaining wait lists would not give a true picture of the demand for services because a person could sign up for treatment services with multiple providers. Therefore, demand for services could be vastly overstated. However, the committee believes people must sign up with multiple treatment providers to access care, there is a widespread problem and DMHAS should be aware of it. Additionally, the department's annual client survey does not include any assessment of client satisfaction with the wait for admission to treatment services.

The department's Regional Action Councils (RACs) are supposed to assist in identifying unmet needs. The councils are public-private partnerships composed of community leaders.

Their stated purpose is to establish and implement action plans to develop and coordinate needed substance abuse prevention and treatment services in their regions.

According to DMHAS, two primary functions of the RACs are to: 1) identify gaps in services along the continuum of care (including community awareness, education, primary prevention, intervention, treatment, and aftercare); and 2) develop an annual action plan to fill gaps in services and to submit the plan to DMHAS. There is no formal quantitative assessment of treatment needs completed by the RACs. The RACS identify priorities in their regions and develop strategies to address perceived gaps within each service area. However, each RAC, within broad guidelines issued by DMHAS, develops it own data using different methodologies making comprehensive comparisons about unmet need impossible. There is no consistent statewide assessment of capacity or demand for any level of service (e.g., detoxification, residential, or outpatient)

Although there have been some limited attempts to collect information about treatment availability, there is no central, well-publicized statewide source of information about capacity or service availability. DMHAS, for example, does conduct a census on residential bed availability each weekday morning. This information is available to other residential providers and could be available to the public if they happened to call the DMHAS central office directly. However, providers have noted that bed availability can change significantly during the day making the census of limited use.

In addition, testimony at the program review committee's public hearing on this topic in October 2008 indicated inconsistencies in intake processes (e.g., whether a person was currently using a drug or not) and extended wait times to be admitted to treatment facilities that were cited as barriers to treatment.

It should be noted that there is one example of a comprehensive treatment delivery system that has a round-the-clock access capability. The Hartford region is served by the Substance Abuse Treatment Enhancement Project (SATEP), which maintains a dedicated centralized 1-800 number available 24 hours per day, 365 days per year, for accessible and timely substance abuse assessment and referral services in the North Central Region. According to SATEP staff, its "ACCESS" line gives both substance abuse providers and clients the ability to initiate intake to residential or outpatient services on a 24-hour-a-day basis. SATEP provides access, transportation, housing, treatment, and coordination, as well as case management, to its clients.

Good management and planning practices require that the demand for treatment services be measured or estimated. An agency following basic strategic planning and business management principles would: a) compare where the agency is now to where it wants to be., in relation to any problem it is trying to address, in order to b) know what progress the agency is making and the success of its interventions. For lead state substance abuse agency, knowing what gaps exist in treatment services is an essential step in this process.

Time to treatment. Related to knowing the demand for treatment is the time it takes for clients to get an assessment and start receiving treatment. DMHAS does not measure the length of time elapsed between when a person makes initial contact with a substance abuse treatment

provider and when that person receives an assessment and substance abuse treatment services. There are many barriers that could prevent the timely intake of potential clients, including lengthy telephone trees or answering machines, limited hours for services, and inattention to intake practices.

Research literature suggests that successful interventions require the time between when substance abusers decide to seek help and when they actually receive services to be as short as possible. In fact, one National Institute on Drug Abuse (NIDA) principle of effective treatment requires that treatment be readily available. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

In addition, the literature notes that reducing the time between intake and treatment increases the number of patients who show up. Often addicted individuals who are forced to wait for treatment lose their motivation to change. By not monitoring and managing this critical time period, opportunities are lost to support the addicted individual from getting timely treatment assistance.

While DMHAS has considered collecting this information, its automated information system for all treatment providers does not currently have the capacity to do so. It has been reported that some treatment providers in Connecticut try to make an appointment within 24 hours of the first contact with a potential client or make accommodations to see people on a walk-in basis. While it is clear some providers do track this information for internal management purposes, it is not known how many actually do track the information or what the results of their efforts are.

Length of treatment. Treatment interventions should be responsive to an individual's needs and particular problems. The exact length of time a person must remain in treatment is difficult to determine because people progress at different rates. However, the National Institute on Drug Abuse stated that "research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment."

In addition, the American Society of Addiction Medicine's patient placement criteria state "research shows a positive correlation between longer treatment and better outcomes." Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness. Multiple studies show treatments 90 days or longer often are indicated for certain substance use problems. This 90-day standard can encompass several levels of care (e.g., detoxification, residential, and intensive outpatient). For methadone maintenance, 12 months of treatment is viewed as the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.

Treatment duration may be less than the recommended period because of various fiscal concerns such as low reimbursements from health insurers or because of individual preferences. National literature suggests the length of substance abuse treatment has declined over the years as health insurers have increasingly turned to implementing managed care practices. On the other hand, many individuals drop out before they receive the full benefits of treatment for a variety of reasons. Some are related to personal motivation and level of support from family members. Program characteristics can also be a factor in client retention. Various strategies

must be employed to ensure appropriate client engagement with treatment services, especially as the system evolves to a more recovery-oriented environment.

DMHAS does not monitor the total length of substance abuse treatment provided to clients and compare it to research-based standards of effectiveness. Nor does DMHAS compare the effectiveness of treatment among individual providers in Connecticut in regard to length of stay. DMHAS' current tracking system can measure length of stay based on each separate level of care.

For one segment of the population, GABHP clients, DMHAS does monitor what it calls "the connect-to-care" rate. The department's connect-to-care rate measures the percent of clients that link to a less intense level of care following discharge from a higher treatment level. DMHAS has stated that the "connect-to-care" rate is a good proxy indicator for a length of treatment measurement. It is loosely related to length of treatment because it attempts to gauge the success at getting clients to engage in longer treatment.

It does not, however, fully capture whether the client receives all the necessary components of treatment. That would require DMHAS to capture data on an episode-of-care basis that would include multiple levels of care. Tracking clients by an episode of care is a broader concept. It is more consistent with DMHAS' recovery philosophy that stresses the long-term nature of addiction. The committee believes a key element of treatment success is ensuring clients enter and complete each level of care that their care plans require. Measuring length of treatment episodes would be a more informative indicator of the system's overall effectiveness.

DMHAS has, however, noted the advantages of meeting the 90-day standard. DMHAS along with the Department of Labor initiated a study of substance abuse treatment effects on wages. Among the several positive effects found by the researchers was the following finding:

> Time in treatment or length of stay (LOS) has been shown to be an important determinant to successful client outcomes. This held true in Connecticut's wage study. Persons with a LOS of 90 days or more had quarterly earnings one year after entering treatment 1.5 times greater than those with a LOS of less than 90 days. This wage advantage for persons with a longer LOS continued two years after treatment.[47]

Inadequate lengths of treatment may result in unsuccessful treatment outcomes. This can lead to the ineffective and wasteful use of finite state resources. As it is, many addicted individuals have multiple courses of treatment; the treatment provided should align with effective practices to reduce the number of recurring treatment episodes.

The program review committee recommends DMHAS shall:

5) assess demand for substance abuse treatment services on a periodic basis through the coordination of wait list information or other methods to identify gaps and

[47] 2004 Biennial Report, *Collection and Evaluation of Data Related to Substance Use, Abuse, and Addiction Programs,* Department of Mental Health and Addiction Services, May 2005, p.16.

barriers to treatment services and report the results in the department's biennial report;

6) **determine a method to track the availability of substance abuse treatment services and provide that information to the public through websites; a toll-free hotline; the statewide human services help line, 2-1-1 (formally Infoline); or other similar mechanisms;**

7) **develop and report on, in its biennial report, process measures that measure the length of:**
   - **time to receive substance abuse assessments and treatment through its provider network and for state-operated services; and**
   - **treatment services received, using the 90-day standard, on an episode-of-care basis.**

Treatment access for DOC inmates. As described in Chapter I, there is a well documented relationship between addiction and crime. Further, research has shown that in-prison treatment, when linked with post-release recovery supports, can reduce post–release drug use and recidivism. However, as noted earlier, thousands of inmates in Connecticut have indicated an interest in participating in substance abuse treatment, but they can not be served.

The DOC system is unable to provide a sufficient supply of addiction services under its current programs and staffing structure. It is unlikely the department will receive funding for any expansion in the near future. Still, the committee finds it may be possible to reallocate existing DOC counselor positions to increase in-facility treatment capacity.

The community service counselors are, as described in Chapter III, employees of DOC. The seven counselors primarily provide outpatient substance abuse counseling services to offenders on transitional supervision and are under the direction of the Addiction Services Unit. Preliminary cost estimates show that it is less expensive to provide residential treatment to an offender in a DOC facility, who is serving an extended sentence, rather than in the community while on parole. The average cost for a residential treatment bed in a DOC facility is about $12,000 per year, based on the salary and fringe benefit costs of counselors, while the cost of residential treatment from a community provider averages about $28,000 per year.

The other costs of incarceration (i.e., facility-related and other overhead) have been excluded because they are required expenditures regardless of whether the inmate chooses to participate in treatment or not. The offenders being served by the community service counselors would need to be provided outpatient treatment services comparable to what they are receiving now and those costs would have to be factored in.

8) **Program review committee recommends DOC should assess:**

   - **the costs and operational implications of transferring community service counselors to DOC facilities to expand**

intensive outpatient and residential treatment offerings in DOC facilities; and

- **in the absence of transferring community counselors, the costs savings that may accrue to treating additional inmates in DOC facilities rather than in residential treatment in the community while on parole.**

Monitoring and Assuring Treatment Service Quality

The program review committee reviewed national research and academic literature regarding model service systems and generally accepted "best practices" for promoting high quality alcohol and drug abuse treatment. After identifying what many consider the key elements for effective treatment programs and services, committee staff tried to determine whether these practices, along with model quality assurance and quality improvement procedures, were in place in the state's substance abuse system.

It was not possible, within the study timeframe, to review whether the model procedures and selected best practices were implemented fully or, if in place, how well they were working. Committee findings, therefore, were limited to identifying the absence or presence of these elements within the state agencies involved in substance abuse treatment for adults. The specific activities examined, and the committee's assessment about their presence within each state agency, are described below. This analysis was based on the review of the main monitoring and quality assurance activities of DMHAS, CSSD, DOC (for both for its in-facility and its parole division programs) contained in Chapter V.[48]

The committee study focused on policies and procedures each agency has in place that relate to four key areas: 1) monitoring and quality assurance activities; 2) selected best practices for effective treatment; 3) outcome and performance measures; and 4) monitoring and evaluation resources. The elements examined in each area, and the committee's assessment of their current status within each agency, are summarized in Table VI-1. Detailed program review committee findings, along with committee recommendations for improving agency implementation of policies and procedures that promote effective substance abuse treatment follow this summary.

Summary of Findings

As Table VI-1 indicates, the program review committee makes the following findings concerning the policies and procedures each agency has in place to monitor programs, promote best practices, and develop and report outcome and performance measures, as well as the agency resources available for monitoring and quality assurance:

[48] A number of fundamental best practices are required by state statute or regulation. In some cases, such as state requirements for developing and regularly updating client treatment plans, compliance is monitored by the Department of Public Health and not the agencies included in the scope of this study. Consequently, certain recognized best practices were not included in this assessment of monitoring and quality assurance efforts.

Table VI-1. Monitoring and Quality Assurance Summary				
	CSSD	**DOC Operated**	**DOC Parole**	**DMHAS**
Monitoring and Quality Assurance Process				
• Contract Compliance Process	Yes	n/a	Limited	Yes
• Corrective Action Plans	Yes	Yes	Limited	Yes
• Dedicated Staff	Yes	Limited	Limited	Yes
• Program Fidelity	Limited	Yes	Pilot	Limited
• Stakeholder Feedback	Yes – not clients	Yes	Yes – not clients	Yes
Selected Best Practices (Substance Abuse Treatment)				
• Substance Use Monitoring				
o Policy on Monitoring	Yes	Yes	Yes	No
o Graduated Sanctions Policy	Yes	Yes	Yes	No
• Research- or Evidence-Based Practices				
o Assessments	Yes	Yes	Yes	Limited
o Programming	Yes	All but one	Yes	No
o Motivational Interview (CSSD and DOC staff; DMHAS providers)	Yes	Partial	Develop	No
o Therapeutic Alliance	Limited	No	No	No
• Discharge Planning and Aftercare				
o Required by Contract/Available	Yes	Yes	Yes	Yes
o Checked by Agency	Yes	n/a	No	Yes
• External Credentialing				
o All Direct Care Staff	No	Yes	No	No
o Programs/facility	All but one	n/a	All but one	Yes
Outcome and Performance Measures				
• Defined	Developing	Developing	Yes	Yes
• Monitored	No	No	No	Yes
• Publicly Reported	No	No	No	No
Resources/Data Systems for Monitoring	Some Capability	Little to None	Little to None	Some Capability

Source: PRI staff analysis

- *DMHAS, DOC, and CSSD all perform various contract compliance activities of varying intensity with nonprofit providers to ensure treatment services are delivered as required; however, the DOC parole division's monitoring appears to be the least comprehensive. CSSD and DMHAS engage in the most extensive monitoring efforts.*

- *CSSD has adopted most of the best practices identified by the committee as related to effective treatment. DMHAS encourages but does not require its provider network to adopt many of the best practices; it does not know the extent to which they are used in state-funded or -operated programs.*

- *DMHAS and the DOC parole division have developed outcome and performance measures for their substance abuse treatment providers; CSSD and DOC-operated programs are in the process of developing such measures. Currently, only DMHAS monitors its performance and outcome measures, but primarily on an individual provider basis. No agency regularly reports the results of its outcome and performance monitoring efforts to the public.*

- *CSSD and DMHAS resources for monitoring and evaluating service delivery, and their electronic data system, appear to be adequate. The Department of Correction's electronic data systems and internal monitoring and evaluation capability do not appear to be sufficient to meet its needs.*

Monitoring and Quality Assurance

The appropriate monitoring of programs should ensure that the contracted services are delivered in the manner required under contract and that service delivery is measured to assess the quality of care. Broadly speaking, quality assurance refers to a process that includes: defining performance goals and/or standards; assessing outcomes in comparison to these goals and standards; and identifying ways to improve performance where desired results are not achieved. This means, at a minimum, each agency should regularly check compliance with contract or program requirements and use the results of monitoring efforts to identify corrective actions to address deficiencies. In addition, an adequate number of staff should be dedicated to this function.

For substance abuse treatment programs, this concept of quality assurance includes obtaining stakeholder feedback and a process for checking fidelity to a treatment program's model practices and required procedures. Stakeholder feedback includes obtaining information about program satisfaction and operations from involved agency personnel and clients. The program fidelity function is key to evidence-based programming, another generally accepted best practice identified by the committee as described below.

Generally, evidence-based programs have shown, through rigorous scientific evaluations, that they can significantly effect important outcomes for participants. To achieve proven positive results, it is important to assure that a program is implemented as designed and tested. The introduction of new staff or changes in treatment duration due to budget limitations can significantly change the delivery of treatment and its effectiveness. Periodic standardized checks help to assure that programs are implemented correctly.

Regarding agency monitoring and quality assurance efforts, the program review committee finds:

- *DMHAS, DOC, and CSSD all perform various contract compliance activities of varying intensity with non-profit providers to ensure treatment services are delivered; however, the DOC parole division's monitoring appears to be the least comprehensive.*

- *All the agencies develop corrective action plans with providers addressing issues of noncompliance or less than satisfactory performance. However, no annual summaries of identified deficiencies are compiled for management purposes by any agency.*

- *All three agencies plus the Department of Public Health perform field inspections of providers. In general, they cover some of the same treatment quality issues for the same providers, but the emphasis of each type of field monitoring is different.*

- *Efforts to check fidelity are very limited, except in one agency. DOC checks for program fidelity for all of its in-facility programs and CSSD was checking program fidelity for three of its 23 program models. The other agencies do not require program fidelity checks and, if performed, they are done sporadically.*

- *Stakeholder feedback is obtained by each agency but the extent of that feedback varies. DMHAS administers the most comprehensive consumer survey of substance abuse clients and shares results with the criminal justice agencies. Feedback on DOC in-facility programs from program participants and DOC agency personnel are obtained during the annual audit process. The DOC parole division and CSSD receive feedback at least annually from providers and related community and department personnel, but not from program participants.*

- *CSSD has begun to implement a risk reduction model for probationer supervision that identifies core practices as well as processes and tools to implement the practices to guide probation officers and supervisors in doing their work. While the procedures to implement the model are not a formal quality assurance process, they provide staff with a guide to implement the risk reduction model with fidelity. The DOC parole division does not have such a model for parole officer supervision.*

- *DMHAS produces an extensive amount of substance abuse treatment provider performance and outcome information. It is not routinely distributed to other agencies to assist with their compliance and quality assurance efforts. In general, the results of contract compliance and other monitoring efforts are not shared among the agencies.*

To improve monitoring and quality assurance of state substance abuse treatment for adults**, the program review committee recommends:**

32) **The DOC parole division should improve its contract monitoring practice and quality assurance processes by including a periodic audit check of its contracted providers to ensure all contract requirements are being met and treatment services are being delivered appropriately.**

33) **DMHAS should investigate, with CSSD, the DOC parole division, and DPH, the development of joint quality assurance and monitoring teams for substance abuse treatment facilities or a common approach for reviewing and checking similar areas of concern and coordinating such review efforts. Either activity should include the development of a corrective action plan summary of compliance issues identified regarding substance abuse treatment providers and the sharing of that information among all agencies.**

34) **CSSD should expand its quality assurance process to include the division's other program models that contain a substance abuse treatment component.**

35) **CSSD should further develop, and the DOC parole division should consider developing, a quality assurance process that assesses the work of probation and parole officers with regard to core practices that assist in reducing criminal behavior and enhancing offender motivation to change, especially for those offenders with a substance abuse problem.**

Later in this chapter, the committee makes related recommendations that pertain to better sharing of the results of DMHAS performance reports and outcome information.

Selected Best Practices for Effective Treatment

Certain approaches and activities that are related to improved treatment outcomes for adults with alcohol and drug abuse problems have been identified in the substance abuse literature as best practices. Selected best practices in four general areas reviewed by committee staff are described below. Committee findings about their use within the state treatment system, along with recommendations aimed at promoting implementation of these best practices, follow.

Substance use monitoring during treatment. The National Institute on Drug Abuse has recognized the importance of regular monitoring of substance use while individuals are in treatment. Because lapses can occur during treatment, objective monitoring for drug and alcohol use can help a client resist the urge to use drugs or alcohol. Early evidence of drug use can also help the provider in adjusting the treatment plan. For those individuals involved with the criminal justice system, recognition of the relapsing nature of addiction requires a graduated sanctions policy for those in treatment.

Use of evidence- or research-based practices. Definitions of evidence- and research-based practices vary in the literature. However, what is common to both is the requirement that

assessment tools and treatment approaches are based on the best available, current, valid, and relevant evidence. The amount and rigor of evidence is usually the distinguishing characteristic between the two, with more stringent substantiation required for evidence-based practices.

Various federal reports over the years, such as a federal Institute of Medicine report "Bridging the Gap between Practice and Research," the 2000 National Treatment Plan prepared by the Center for Substance Abuse Treatment, and the SAMHSA "science-to-service" initiative, have called for the adoption of research findings into routine clinical practice. It is also suggested that the limitations of current research about particular populations be understood and factored into any evaluations of treatment programs.

Often, intentional and unintentional adaptations are made to evidence-based programs. As noted above, improperly trained or monitored staff or fiscal concerns can change how a program is implemented -- emphasizing the importance of program fidelity checks. However, many of those interviewed by committee staff have cited a mismatch, such as cultural differences, between evidence-based programs and the actual participants as a reason for altering evidence-based programs. This is sometimes cited as a reason not to adopt an evidence-based program in the first place. However, the research literature suggests that not all adaptations are fatal.[49] Certain adaptations, such as language changes, replacing cultural references or images, or modifying certain activities, do not appear to limit effectiveness. Other changes that impact the core of the programs, such as the length of the program or using improperly trained or fewer staff, will impact program effectiveness.

In addition to evidence-based assessment tools and programs, the committee also considered motivational interviewing and the measurement of the "therapeutic alliance" as important evidence-based practices. As explained earlier, motivational interviewing techniques include strategies such as asking open-ended questions not easily answered with a single word or phrase, listening reflectively to a client and repeating back what was said back, affirming the client's recognition of a problem and intention to change, and eliciting self motivational statements from the client that recognize his or her problems and express an intent to change. Assertive outreach and motivational interviewing assists individuals in initiating and maintaining the path to recovery. Motivational interviewing is not only an important skill for counselors but also for those who perform assessments and develop and monitor case plans of offenders, such as parole and probation officers.

The therapeutic alliance refers to the relationship between a counselor and a client. A positive therapeutic relationship has been cited as a principle factor in treatment success. An analysis of 79 studies that examined the therapeutic alliance between therapists and clients found a positive relationship between the strength of that alliance and successful treatment outcomes. [50]

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[49] Cailin O'Connor, Stephen A. Small, and Siobhan M. Cooney, "Program Fidelity And Adaptation: Meeting Local Needs without Compromising Program Effectiveness*," What Works, Wisconsin Research to Practice Series*, 4. Madison, WI: University of Wisconsin–Madison/Extension.

[50] Daniel Martin, John Garske, and M. Katherine Davis, "Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review," *Journal of Consulting and Clinical Psychology*, Vol. 68, No. 3, 438-450.

The NIDA principles for effective treatment also note the importance of the counselor establishing a positive therapeutic relationship with the patient to help keep the patient in treatment long enough to gain the full benefits of treatment.

Discharge planning and aftercare. Recovery from substance use disorders can be a long, complex process. Research shows better outcomes are achieved when formal clinical treatment is followed by aftercare services and combined with other recovery supports. Referrals to community-based self-help groups and assistance with housing, transportation, employment, and basic needs are among the practices found effective in helping clients sustain recovery and maintain abstinence. The NIDA principles suggest that substance abuse treatment providers should be expected to assist in ensuring a transition to continuing care.

External credentialing of facilities/programs and treatment providers. A variety of substance abuse treatment authorities emphasize the importance of a well-trained, competent workforce in delivering effective services. More complex treatment issues call for more sophisticated and competent treatment skills. Research and evaluation studies are identifying new methods and tools for facilitating change and recovery requiring on-going professional development. Treatment programs also are seeing clients who have co-occurring disorders and complex life situations and issues. The promulgation of new methods and clients with multiple disorders emphasize the need for a broad spectrum of counselor competencies that may not be sufficiently learned through on the job training.

Proxy measures for a well-trained workforce that are used in this report include the extent to which substance abuse treatment professionals and facilities are credentialed (i.e., have appropriate licenses or certification from the Department of Public Health). Another measure is the extent to which substance abuse treatment programs and facilities are accredited by nationally recognized organizations, such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF).

The Department of Public Health is responsible for the licensing of treatment programs in the state and administers the licensing and certification program for drug and alcohol counselors. As part of its licensing responsibility, the department conducts biennial inspections of treatment facilities. This inspection assures that treatment programs are meeting a minimum regulatory standard of care. The department's inspections encompass a number of areas including the condition of the physical plant, the presence of staff with certain training and credentials, and the adequacy of treatment plan documents and other patient records. The inspection does not include items not covered in regulation or statute, including best practices or effectiveness of treatment, staffing ratios, intake practices, or the existence of evidence-based assessment tools or programs. Most of the current regulations were promulgated in 1988, though some portions were updated in 1999.

The program review committee makes the following findings regarding identified best practices for effective substance abuse treatment:

- *The criminal justice agencies all have general policies regarding testing individuals in treatment for substance use and have a graduated sanctions policy to handle substance use during treatment. DMHAS does not have a*

general policy and does not compile or analyze information about provider testing procedures or testing results.

- *CSSD and the DOC parole division require that contracted substance abuse treatment providers' assessment tools and programs be evidence- or research-based, though the definitions of research or evidence-based practices are not always clearly defined. DOC and CSSD also use evidence-based and validated assessment tools to determine offender needs.*

- *The DOC parole division does not consider treatment received in prison when making a referral to treatment services and may be filling residential treatment beds inappropriately.*

- *The Board of Pardons and Paroles does not receive a complete picture of offender needs when the offender's case is presented to the board because a needs assessment is administered after parole decisions are made.*

- *The DOC's in-facility assessment tools are evidence-based but one is not validated against a correctional population; its treatment programs all are evidence-based, except for one.*

- *DMHAS requires use of specific evidence-based screening tools but providers can use whatever process and tools they want to assess client treatment needs as long as a comprehensive biopsychosocial assessment is performed and standardized placement criteria are followed.*

- *CSSD has trained its probation officers in motivational interviewing (MI) techniques, while the DOC parole division is in the process of training its parole officers in this technique. New counselors that are employed by DOC for in-facility treatment programs are trained in MI, and the training is offered to existing counselors but is not required. DMHAS offers training in MI and other evidence-based practices through its education and training division courses.*

- *DMHAS encourages providers to use evidence-based practices but does not mandate their use.*

- *CSSD is the only agency currently trying to measure the therapeutic alliance through the use of an evidence-based, validated assessment tool; however, it is doing so in only one of its program models.*

- *Each of the agencies has discharge planning requirements that must be followed by all its funded or operated treatment programs. Data on the*

number of substance abuse clients who receive services to support their recovery and related outcome information are not systematically tracked.

- *All facilities that provide substance abuse treatment services must be licensed by DPH. However, both the DOC parole division and CSSD report that one of their providers is not licensed by DPH.*

- *Only DOC alcohol and drug treatment counselors are required to be licensed or certified. All other agencies, including DMHAS, do not require that programs employ only credentialed counselors to provide clinical treatment services.*

- *State law does not require that treatment counselors be licensed or certified but does require noncredentialed staff of substance abuse treatment facilities to be supervised by licensed professionals if they render clinical services, such as assessments. It is unclear how well this is monitored and enforced. Supervision is not defined in either statute or regulation.*

- *Making licensure a "blanket" requirement could create problems as providers report there is a shortage of credentialed staff now. Mandating higher qualifications for direct care staff also is likely to be costly to providers and funding agencies.*

- *Information on the substance abuse assessment instruments and procedures used by treatment programs, or their supervision policies for staff who are licensed or credentialed, is not compiled by DMHAS.*

- *Specific information about client populations served, language competence of staff, problems and disorders treated, and program specialties is not compiled by DMHAS although it is collected from providers who are certified to participate in GABHP.*

- *DMHAS maintains no centralized inventory of the types of substance abuse treatment services the programs it funds or directly operates provide, or whether programs are evidence-based or nationally accredited.*

- *DMHAS does not collect and report data on the number of substance abuse clients who receive services to support their recovery or any outcome information related to such services.*

To promote implementation of best practices for effective treatment, **the program review committee recommends:**

36) DMHAS should compile and analyze information about provider substance use testing procedures, create a uniform policy, and ensure that regular testing is performed and best practices are followed.

37) DMHAS shall establish a clear definition of research- and evidence-based practices and develop a strategy to encourage the use of such practices for substance abuse assessments and treatment, including program fidelity checks and measuring of the therapeutic alliance. The strategy shall be developed by January 1, 2010.

38) DMHAS should collect and report data on the number of substance abuse clients who receive services to support their recovery and any related outcome information.

39) The DOC parole division should ensure that all treatment information is considered when referring clients for additional substance abuse treatment, including the treatment received while in DOC facilities and any discharge planning developed by the Addiction Services Unit. The division should ensure that all referrals to residential treatment are made appropriately.

40) The Board of Pardons and Paroles should consider having the evidence-based assessment tool called the Level of Service Inventory administered by parole officers before a final decision is made by the board regarding parole eligibility and conditions of parole.

41) DOC and CSSD shall ensure that all substance abuse treatment providers are properly licensed as required by law.

42) DMHAS shall develop a strategy to encourage the development of licensed or credentialed staff in providing clinical services within all state-funded and -operated substance abuse treatment programs. Such strategy shall consider a long-term phase-in of such a requirement. The strategy shall be developed by January 1, 2010.

43) DMHAS shall compile a profile of each substance abuse treatment provider that receives state funding. This provider profile shall be updated on an annual basis and be maintained on the department's website. Both DMHAS and DOC also shall create a similar profile for the programs they operate. The profile shall include:

- **client populations served;**
- **language competence of staff;**
- **types of care available and the number served at each level of care;**
- **extent to which services are evidence-based or not;**
- **accreditation status of the provider;**
- **client survey results;**
- **the percent of employees who are licensed or credentialed who perform assessment, treatment plan development, and treatment delivery services; and**

- **treatment completion rates by level of service, average wait times for treatment services, and outcome information, including the federally required National Outcome Measurement System data, and any other information DMHAS deems relevant.**

Outcome and Performance Measures

Collecting information on outcome and other performance measures is critical to ensuring system accountability and identifying strengths and weaknesses of various treatment approaches. Outcome measures assist organizations in continually measuring how well services or programs are achieving the desired results. Ultimately, they should provide a basis for collecting reliable evidence about program operations that can be used as a basis to guide the development of budgets, allocating resources, and improving services.

Regarding information for system accountability, the program review committee finds:

- *Only DMHAS gathers outcome and performance measures for the substance abuse treatment programs it funds and operates. This information is generally not shared with other state agencies that also use the programs.*

- *There is no systemwide systematic tracking of the connection to the next level of care for clients, or success in maintaining recovery for people with substance abuse problems who are discharged from DOC and CSSD custody to the DMHAS system.*

- *While some academic studies have examined substance abuse treatment and recidivism for the criminal justice agencies, there is no consistent, on-going check of those participating in particular programs and recidivism, though CSSD is in the process of developing this capability.*

- *Results from DMHAS' many research and evaluation activities are not compiled in a central location and there is no unit or group of staff dedicated to promoting systemwide best practices and quality improvement.*

- *At present, there is no link between cost of services and program outcomes and none of the agency contracting is based on provider performance outcomes.*

- *DMHAS collects an extensive amount of performance and outcome data regarding all the behavioral health services it funds and operates. It tracks substance abuse treatment effectiveness in many ways, but mostly on a program and individual client basis.*

- *Outcome information for treatment that is funded or operated directly by DMHAS is not routinely aggregated or periodically summarized and reported publicaly. As the lead state agency for substance abuse, the department should be compiling and analyzing all available outcome data and research findings to evaluate overall effectiveness of the publicly funded treatment system.*

- *While considerable amounts of performance and outcome data are produced about publicly funded substance abuse treatment, there is little internal capacity for analysis and research within any state agency.*

- *Research projects carried out specifically to assess substance abuse treatment in Connecticut have produced findings that echo national studies, showing:*

    - *state substance abuse treatment is positively related to subsequent improvements in substance use, homelessness, criminal behavior, employment, and use of health and mental health services;*
    - *completing state treatment programs has a positive impact on employment status and treatment lasting 90 day or more had the best results;*
    - *state substance abuse treatment has a positive impact on recidivism; and*
    - *state substance abuse treatment provided with recovery supports like housing, transportation, vocational assistance, and basic needs assistance is more effective than treatment alone.*

- *DMHAS gathers and reports on the federally mandated National Outcome Measures (NOMS) for all substance abuse providers. These measures currently are inadequate as they only provide a gross sense of the effects of the state's substance abuse treatment system. However, the NOMS are the best available data regularly produced about the effectiveness of publicly funded substance abuse treatment.*

- *DMHAS does not regularly compile or publicly report the national and any of its other outcome measures for the state substance abuse treatment system.*

- *NOMs information developed by the department at the request of the committee shows that for a recent three-year period, about one-third of all discharged clients (both those completing and not completing their state treatment program) showed improvement in the alcohol abstinent measure, and around one-quarter showed improvement in the drug abstinent measure, for each year.*

- *DMHAS also provided the committee with data on completion rates by level of care that show, in total, about two-thirds of adults who entered state substance abuse treatment completed their level of care. Completion rates varied greatly among the care levels and were higher for residential than outpatient programs. Completion rates for more intensive residential programs were highest (80 to 85 percent) while outpatient levels of care had the lowest rates of completion (45 to 55 percent).*

- *The department did not provide NOMs data for state methadone maintenance programs and does not compile or report results information related to this level of care. Given the importance of this treatment approach in Connecticut, and the stigma and controversy associated with methadone and other opioid replacement treatment, developing and reporting information about its effectiveness should be a DMHAS priority.*

- *DMHAS also does not compile and report performance and outcome information specifically for the four substance abuse facilities it operates.*

- *Treatment completion is linked to successful outcomes. It is unclear how successful DOC program completion rates are when compared to those of private providers. Completion rates are over 60 percent for private provider long-term residential treatment, while at DOC the rate is 35 to 48 percent, depending on the program. Intensive outpatient completion rates for private providers are between 48 to 55 percent, while the DOC rate is 75 percent. Regular (non-intensive) outpatient treatment completion rate for private providers is 45 to 51 percent, and 15 to 45 percent in DOC's Community Addiction Service Programs.*

- *Together, DMHAS and CSSD operate two drug and alcohol education diversion programs for certain first time offenders: the Pretrial Alcohol Education System (PAES); and the Pretrial Drug Education Program (PDEP). Although they serve over 12,500 individuals a year, the programs have not been formally evaluated. Neither agency could provide the committee with performance and outcome information on the PAES and PDEP programs within the study timeframe.*

In response to its findings about outcome and performance measures for the state substance abuse treatment system**, the program review committee recommends:**

44) CSSD and DOC should calculate completion rates for those clients enrolled in their substance abuse treatment programs. CSSD and DOC should benchmark their completion rates against programs offered by other similar criminal justice and correctional agencies. In addition, DOC should evaluate whether its contracted community private providers produced better completion rates and outcomes than offenders on parole and receiving services from DOC.

45) **DMHAS, in conjunction with CSSD, should conduct an evaluation of the effectiveness of the PAES and PDEP programs, in terms of their impact on participant substance use and criminal justice involvement. The agencies also should develop outcome measures for both programs that are reported, at a minimum, in the DMHAS biennial report, beginning in 2010.**

46) **DMHAS should develop and review the performance and outcome information related to the state's methadone maintenance and other opioid replacement treatment programs by July 1, 2010. The information should be summarized and reported on the agency's website and in the department's biennial report. At a minimum, it should include: how long people remain in treatment; whether providers are in compliance with all state and federal standards; and what improvement clients have experienced in their substance use and quality of life because of the treatment they received.**

47) **The annual State of Connecticut Recidivism Study generated by the Criminal Justice Policy and Planning Division of the Office of Policy and Management should evaluate and report the effects of substance abuse treatment received by offenders on subsequent criminal justice involvement.**

48) **DMHAS, as the lead state substance abuse agency, should expand and strengthen its role in developing, gathering, analyzing, and reporting outcome measures regarding the effectiveness of the state's substance abuse treatment system.**

Additional improvements recommended by the committee that are related to the department's role, as lead state substance abuse agency, in supporting monitoring and evaluation of the state treatment system are discussed later in this chapter.

Monitoring and Evaluation Resources

An agency's monitoring and evaluation capability is dependent on the resources the agency commits to such efforts. A brief overview of the resources each agency has devoted to monitoring and evaluating its treatment programs and services is provided in Chapter V, along with a description of agency research on treatment outcomes conducted by outside consultants or through academic partnerships. That chapter also includes a discussion of the various information systems available in each agency, since high-quality automated systems support collection and retrieval of data that allows for the analysis of treatment program efficiency and effectiveness.

Based on the information presented in Chapter V, the program review committee finds:

- *Data systems and research capabilities vary widely among the agencies.*

- *CSSD has 12 staff dedicated to performing contract compliance activities and another 17 employees who staff two separate offices dedicated to best practices and quality assurance.*

- *Generally, both DOC in-facility programs and parole division contractors are monitored by in-house staff who have other job responsibilities in addition to performing monitoring audits. The parole division reports not having sufficient staff to perform the contractor monitoring oversight function.*

- *In total, about 29 DMHAS professional staff are assigned full-time to contract compliance and program monitoring functions for the department's entire network of behavioral health service providers (approximately 200 programs) and its four state-operated facilities.*

- *DMHAS has four professional staff for all internal planning and research functions. It has established partnerships with several universities to conduct prevalence and treatment need studies as well as outcome evaluations of treatment services.*

- *DOC, partially because of its limited automated information systems, has little capacity for internal data analysis. The current automated system at CCSD also is limited but the division is developing a comprehensive contractor database that will collect key treatment data on individual clients to gauge performance of its provider network.*

- *DMHAS collects the most information about substance abuse treatment services from all licensed providers in Connecticut, as well as from DOC-operated and its own programs. It has experienced extensive data quality issues within its treatment provider information system. Corrective actions have been on-going since 2005, but this effort will not be complete until early 2009. Technical problems also have impeded DOC access to the system and it contains only a portion of that agency's substance abuse treatment data.*

- *DMHAS has three automated information systems: one that collects data from substance abuse treatment providers; a separate system for department-operated facilities; and one for the General Assistance Behavioral Health Program.*

- *Data quality has been an ongoing issue for DMHAS' provider information system; a major data integrity improvement project started three years ago is expected to be completed early in 2009. The system for the state facilities has little ability to produce management information. Upgrades for both the provider and facility systems are planned and should be in place by the spring of 2010.*

- *A separate automated system, with generally more reliable data, is maintained by the program's ASO. It is capable of producing any number of routine and ad hoc reports about GABHP clients, the treatment and recovery support services they receive, and costs of care provided.*

- *All three agencies have developed relationships with academic institutions to supplement their internal resources for research and data analysis.*

- *At this time, results from DMHAS' many research and evaluation activities are not compiled in a central location and there is no dedicated best practices unit.*

The state's current fiscal situation and related budgetary constraints limit options for addressing agency resource needs at this time. **Therefore, the program review committee recommends:**

49) DOC should conduct an assessment of its management information system to determine how it could better meet its research and management needs.

Related recommendations concerning DMHAS's role in supporting monitoring and evaluation of the treatment system, as the state lead substance abuse agency, are discussed in the following section of this chapter.

Lead Agency Role

Lead responsibility for the state's substance abuse treatment system for adults rests with the Department of Mental Health and Addiction Services under a number of statutory mandates. State law requires the department to develop and implement a statewide substance abuse plan and to chair the state interagency council on alcohol and drug policy, which also has statewide planning and coordination duties. The department is charged with maintaining a central data repository for all substance abuse services provided in the state and reporting on the use, quality, and effectiveness of the publicly funded treatment system every two years.

DMHAS is Connecticut's designated single state agency for substance abuse treatment and prevention for federal funding purposes. In this capacity, and in accordance with several state statutory mandates, the department must coordinate state policies and resources, as well as publicly funded programs and services, for treating adults with substance use disorders. As discussed more fully below, the committee believes the department, as the lead agency, needs to take a stronger role in a) planning; and b) coordinating and overseeing the state's substance abuse treatment for adults.

In brief, the committee finds DMHAS has:

- *no strategic planning process for the publicly funded treatment system;*

- *been deficient in promoting consistent standards and the use of best practices across agencies and the private provider network; and*
- *not compiled, monitored, and reported information about the overall impact of the state treatment services on the adult substance use problem in Connecticut.*

Comprehensive Strategic Planning

DMHAS is involved in multiple planning processes concerning substance abuse treatment and prevention. Under C.G.S. Sec. 17a-451, the department must develop and implement a statewide substance abuse plan, which is defined as: a comprehensive plan for prevention, treatment, and reduction of alcohol and drug abuse problems that includes statewide, long-term goals and objectives that are revised annually. Another statute requires the state Alcohol and Drug Policy Council (ADPC) to develop and coordinate an integrated, interagency plan for substance abuse programs and services; it must submit a report evaluating plan implementation, with recommendations for proposed changes, to the legislature each year.

DMHAS views the council's annual substance abuse reports as meeting the mandate for a comprehensive state substance abuse plan; it does not prepare another document. The committee found the ADPC reports identify major substance abuse problems in the state, make recommendations for addressing them, and outline necessary implementation activities and resources. However, while the council reports set priorities for statewide policy and practice, they do not constitute a comprehensive plan for delivering effective treatment to adults.

By law, the department's statewide substance abuse plan must be developed in consultation with the state's regional planning and action councils for substance abuse treatment and prevention (RACs). DMHAS carries out an extensive regional priority planning process with the RACS (described earlier) but the councils have not had any role in the Alcohol and Drug Policy Council's planning process.

Further, the current regional planning process primarily is a systematic way for the department to bring together information on gaps and cross-regional needs. It is used to reach consensus, with broad stakeholder input, on state funding priorities but it does not result in a comprehensive state plan of action for providing effective substance abuse treatment.

This process also contains no formal tracking of progress made in addressing the identified regional and state priority needs. For example, over the past five years, housing and transportation always have been identified as two top priority unmet needs of substance abuse clients by all RACS. While a number of initiatives have been undertaken at the state and local levels to address these issues, their effect, in terms of improving clients' treatment outcomes, is not measured or reported. In interviews with PRI staff, RAC members noted they receive little feedback on the actions taken in response to their regional priority plans and whether recommended changes are having any positive impact.

In recent years, a top state priority has been effective substance abuse treatment and recovery support for adults involved in the criminal justice system. As discussed earlier, DMHAS is involved in a number of collaborative projects with CSSD and DOC intended to increase and improve services for offenders with substance use disorders who are remaining in or returning to the community. Many initiatives in all three agencies are targeted to providing treatment to this population, but there is no formal plan with goals and outcome measures guiding them at present.

By law, the Criminal Justice Policy and Planning Division within the Office of Policy and Management must develop a reentry strategy to promote successful transition of offenders from incarceration to the community. One of the many areas the strategy must address is how to link newly released offenders with community-based programs and services proven effective in reducing recidivism, such as substance abuse treatment and recovery supports. The final draft of the division's community reentry strategy is expected to be issued for review in December 2008 and finalized by the following February. The committee believes the strategy could partially address the need for better planning for the delivery and coordination of treatment services to the criminal justice population.

Overall, PRI staff found the state has no strategic planning process for its publicly funded substance abuse treatment system. Current planning efforts are disjointed and existing plans and reports provide piecemeal approaches for meeting the needs of adults with substance use disorders. For the most part, these documents identify priorities and initiatives for addressing them, not measurable goals and comprehensive strategies for achieving them They also fail to provide a framework for assessing progress toward state goals for substance abuse treatment.

In addition, the program review committee found there is no clearly articulated state policy on substance abuse treatment in statute or any state agency document. Current law does not directly address the purpose of the department's services for adults with substance use disorders or establish goals across the entire treatment system.

The department's main statutory requirement regarding the publicly funded treatment for alcohol and drug dependent persons is to provide programs and services, within available resources, for the purpose of "early and effective treatment." The commissioners of DMHAS and DOC also are directed by law to cooperate in establishing treatment and rehabilitation programs for alcohol and drug dependent persons confined in correctional institutions. State statute additionally requires that substance abuse treatment funded or directly provided by DMHAS be guided by the following standards:

- Treatment on a voluntary rather than involuntary basis, if possible
- Initial assignment or transfer to outpatient or intermediate treatment, unless inpatient treatment is found to be required
- No denial of treatment solely because of withdrawal from treatment against medical advice on a prior occasion or relapse after earlier treatment
- Preparation and maintenance of a current individualized treatment plan for each patient

- Provision for a continuum of coordinated treatment services so a person leaving a facility or form of treatment will have available and utilize other appropriate treatment

However, none of these mandates have been incorporated into a vision and mission statement for state substance abuse treatment or developed as goals and objectives for DMHAS programs and services. Providers, regional planning council members, and advocacy group representatives interviewed by the committee staff were unaware of any official department policy concerning goals or expected outcomes specific to the state's alcohol and drug abuse treatment system.

At present, there is no state plan or written policy that contains formal, well-defined performance goals, or related benchmarks, to guide DMHAS and other state agencies in providing and evaluating substance abuse treatment services. Without clear goals that address how well the system is getting and keeping people in treatment and what difference the treatment provided is making in terms of improvements in a person's substance use and quality of life, it is difficult to assess the effectiveness of the state's substance abuse treatment system.

As described earlier, the department has adopted clear vision and mission statements, developed with broad stakeholder input, for its recovery-oriented system of care, which apply to all behavioral health services DMHAS supports. They are contained in formal policy statements issued by the commissioner and lay a foundation to guide agency operations and resource allocation. They are also reflected in a detailed manual of practice guidelines for all department funded and operated treatment programs.

According to the commissioner, the recovery-oriented care policies and guidelines are intended to serve as a framework for ensuring a system of "… quality care [that] is safe, timely, person-centered, effective, efficient, and equitable…." It has also been stated in department presentations that, while the eventual goal of treatment is to end dependence, a recovery-oriented system: decreases severity of symptoms; and increases duration of abstinence. The committee believes these various recovery-oriented policies and guidelines could serve as a foundation for a comprehensive strategic planning process focused on the agency's substance abuse treatment system.

Comprehensive strategic planning is the cornerstone of effective management and clear accountability. As noted in SAMHSA technical assistance documents, a good strategic plan: specifies what will be accomplished over a three-to-five year period; sets annual performance targets related to the plan; and every year reports on the degree to which those targets are met. In addition, planning should be based on clear, succinct, and widely supported mission and vision statements developed in collaboration with stakeholders. The many benefits of good strategic planning include: clear, consistent goals to guide policy and resource decisions; relevant measures of progress; and well-defined action steps.

A strategic statewide plan for the adult substance abuse treatment system would address a number of current deficiencies. It would create a formal, clearly articulated state policy to guide development, implementation, and evaluation of all publicly funded adult substance abuse

programs and services. The process would promote systematic analysis of existing capacity and current and projected demand. Given the likelihood of significant funding constraints in the coming years, the plan could be a valuable guide for allocating resources in a cost-effective manner. Finally, it would provide a formal framework for tracking progress, holding private providers and state agencies accountable for results, and informing managers and policymakers about areas of success and areas in need of improvement.

Therefore**, the program review committee recommends:**

50) Current statutory provisions for a statewide substance abuse plan shall be repealed and replaced with a requirement for a strategic planning process for the state substance abuse treatment system for adults that is overseen by DMHAS.

Beginning in 2009, the department shall prepare and annually update a three-year strategic plan for providing state treatment and recovery support services to adults with substance use disorders. The plan shall be based on a mission statement, a vision statement, and goals for the state treatment system, including all state-funded and state-operated services, that are developed by DMHAS, in consultation with: its regional action councils; consumers and their families representing all client populations including those involved in the criminal justice system; treatment providers; and other stakeholders.

The strategic state substance abuse plan shall outline the action steps, timeframe, and resources needed to address the goals developed with stakeholders. At a minimum, the plan shall address the following areas:

- **access to services, prior to and following admission to treatment;**
- **comprehensive assessment of the needs of those requesting treatment, including individuals with co-occurring conditions;**
- **quality of treatment services and promotion of best practices, including evidence- and research-based practices and models;**
- **provision of an appropriate array of treatment and recovery services along a sustained continuum of care;**
- **outcomes of specific treatment and recovery services and of the overall system of care; and**
- **department policies and guidelines concerning recovery-oriented care.**

The plan also shall define measures and set benchmarks for assessing and reporting on progress in achieving the plan goals, statewide and for each state-operated program. These should include, but not be limited to: timeliness (e.g., portion of clients admitted to treatment within one week after referral); penetration rates (percent of those needing treatment who receive it); completion rates; connection-to-care rates; length of treatment episode (e.g., portion of clients receiving treatment of 90 days or more); and rates of client improvement regarding substance use,

employment status, stable housing, criminal activity, and relationships with family and community.

The first three-year plan shall be completed by July 1, 2010. DMHAS shall submit final drafts of the initial plan and its annual updates to the state Alcohol and Drug Policy Council for review and comment. Progress in achieving the plan's goals shall be summarized in the department's biennial report on substance use that is submitted to the legislature and the council under C.G.S. Section 17a-45.

In addition to the plan content areas outlined above, the committee identified two additional issues that should be addressed by the department's new strategic planning process, at least for the initial plan. First, to ensure an integrated approach is taken in addressing the substance abuse needs of adults within the criminal justice population, **the program review committee recommends:**

51) **provisions of the community reentry strategy developed by the Criminal Justice Policy and Planning Division regarding substance abuse treatment and recovery services needs of the offender population shall be incorporated within the state strategic plan.**

Further, DMHAS shall consult with the Criminal Justice Policy Advisory Commission in developing goals related to the special treatment and recovery service needs of adults involved in the criminal justice system, as well as strategies for meeting them, for the new state substance abuse plan. A work group composed of staff from CSSD, DOC Addiction Services, DOC Parole, and the DMHAS Forensic Services Division, and representatives of private nonprofit providers of adult substance abuse treatment services, should be formed to assist with this process.

The second issue is related to the lack of good information linking funding and service outcomes that could be used for strategic planning purposes as well as better accountability. *At present, there is little to no data on the actual costs of providing care to the different client populations. Also, there is no document outlining the resources required to continue providing services at current or alternative levels.*

At the committee's October 2008 public hearing and in interviews with staff, private providers reiterated on-going concerns about their financial viability given continually rising operating costs and essentially stagnant state funding over the last decade. Private providers described the state's nonprofit human services as "grossly underfunded" and "severely challenged." According to the Connecticut Community Providers Association, compounded cost of living adjustments (COLAs) to state payment to nonprofit providers from 1987 to 2008 totaled 29.3 percent, while the compounded inflation rate (CPI) was 95.4 percent. Providers have received only one cost of living adjustment to rates paid under the General Assistance Behavioral Health Program since its inception in 1998.

The community providers association pointed out that decades of underfunding has lead to many problems, including pay disparity and a high employee turnover rate. According to

providers, nonprofit staff, in some cases, are paid at about one-half the rate of comparable state employees. This disparity causes employees to leave the nonprofits to join state agencies or pursue other more lucrative employment opportunities. The turnover rate is reported to be about 26 percent for direct care staff, with a vacancy rate of 8 percent. This impacts the quality and effectiveness of care as it can be disruptive to the relationships built between clients and therapists. In addition, other providers have pointed to shrinking programs and deferring maintenance and repair of buildings because of a lack of funding.

Determining the impact of the state's funding methods and potential underfunding of the nonprofit treatment community is beyond the scope of this study. However, it is notable that in interviews with PRI staff, none of the individuals from state agencies who provide funding to nonprofits had a firm understanding of the financial status of the state's provider network. Even though DMHAS collects a considerable amount of fiscal and operating information about its nonprofit agencies, it was unable to provide PRI staff with: any assessment of the financial condition of its network; or complete data on the costs associated with different levels of care.

The private provider network could not be easily or economically replicated by direct state services. Because of the vital role that nonprofit providers fulfill, combined with the lack of information about their financial viability, the **committee recommends:**

52) DMHAS shall conduct a financial viability assessment of its private provider network. This assessment should estimate the extent to which the community providers have the ability to appropriately meet their clients' needs and their mission in a sustainable way over the next five to ten years.

Coordination and Oversight

State statutes do not refer to DMHAS as the lead agency for substance abuse. However, it is mandated to carry out a number of statewide coordination and oversight functions for alcohol and drug abuse treatment and prevention that give it that role. For example, the department must:

- prepare and issue regulations for administration and operation of all DMHAS, state-operated, and community programs for persons with substance use disabilities;
- establish and enforce standards and policies for care and treatment of persons with substance use disabilities in public and private facilities;
- coordinate all activities in the state relating to substance abuse treatment including activities of the Judicial Branch and all other departments or entities providing such services;
- collect, make available, and specify, for public and private agencies, uniform methods for keeping, statistical information on alcohol and drug abuse treatment and prevention that includes: numbers treated; demographic and clinical information; information on admission and readmission; discharge and referral; treatment frequency and duration; and levels of care provided;

- establish, and with OPM ensure compliance with, uniform policies and procedures for collecting, standardizing, managing, and evaluating data on all state substance abuse programs including: use of services, demographic and clinical information, and service quality and effectiveness; and
- submit to the legislature a biennial report on the above substance abuse program data that summarizes: client demographic information; trends and risk factors; service effectiveness (outcome measures); and a state-wide cost analysis.

DMHAS engages in many joint planning processes and collaborative initiatives to promote interagency coordination of substance abuse treatment policies and resources. The department is leading many of the ADPC interagency coordination efforts and is an active member of the Criminal Justice Policy Advisory Commission. A number of promising collaborative projects have been developed by the agency's Forensic Services Division and the state's criminal justice agencies. The Access to Recovery program is another example of a successful collaborative effort, lead by DMHAS, to link treatment and recovery services and provide them to adults with substance use disorders in criminal justice, child welfare, and behavioral health care systems.

In most cases, it is too early to know the outcomes of these joint programs in terms of reducing clients' substance use and criminal involvement. However, staff from the participating agencies report positive initial results, including better communication among all departments and significantly improved interagency cooperation. Independent, formal evaluations of program effectiveness are planned and will be used to determine effectiveness as well as areas for improvement and expansion.

DMHAS has implemented a collaborative contracting process. The project has streamlined the procurement and contract management process for obtaining residential treatment services for DMHAS, DOC, and CSSD adult clients with substance use disorders. According to the department, the project has keep the rates paid by each agency for residential treatment beds more uniform and significantly reduced the administrative burden on the 12 providers who participate in the collaborative contract.

Conceptually, the project seems to be a cost-effective practice that could be expanded to other services. However, there has been no formal review of direct or indirect cost savings for the state or the provider agencies. Also, while CSSD feedback on the project has been very positive, DOC has been dissatisfied with certain procedures and its access to residential treatment beds.

As noted in Chapter V, DMHAS has been deficient in promoting consistent standards and coordinating agency efforts to achieve effective substance abuse treatment in several important areas. In addition, the program review committee staff identified several instances where a lack of interagency coordination is contributing to unnecessary duplication, inefficient use of resources, and, in some cases, quality of care issues for clients. (See, for example. earlier findings regarding multiple state agency field inspections of the same private providers). At its public hearing in October 2008, the PRI committee received testimony from providers that, when

funded by multiple state agencies, they must file essentially the same financial data on up to three or more forms. Committee staff confirmed this during site visits of several contracted substance abuse treatment agencies.

Providers also cited cases where they are required for billing reasons to schedule substance abuse and mental health treatment sessions on consecutive days, rather than having clients receive both required services during one trip to a facility Some providers also believe they must close out client records prematurely to be in compliance with administrative reporting requirements, even though this results in duplication of effort for the provider and client, and unnecessary expense for the service funder, when an individual returns to active treatment in a short amount of time.

Another example of costly duplication is the fact that agencies providing both mental health and substance abuse services must have two separate licenses from the Department of Public Health. DMHAS has been involved in a public health department project to develop a combined behavioral health care license for such providers. Until about six months ago, it also was working with DPH staff to update long-outdated regulations on substance abuse treatment.

At this time, it appears both initiatives are under internal review with DPH and the timeframe for completion is unclear. Opportunities to streamline administrative procedures and create efficiencies should not be missed, particularly given the state's current fiscal climate.

In terms of coordinating information, DMHAS has made considerable progress in maintaining a centralized repository of substance abuse treatment data as required by state statute. Also, as mandated, it is producing the statewide biennial report on substance abuse. The report is a true interagency document that contains: cross-agency data on inputs and outputs for substance abuse treatment; and information on trends in substance use and abuse based on consistent definitions and methodologies.

While the biennial report is required to contain a summary of service effectiveness in terms of treatment outcomes, along with a statewide cost analysis, only agency-level expenditure information is provided at this time. *In general, examination of spending by level of care, by type of treatment program, or per client is not possible with current data systems and staff resources.*

The lack of coordinated information systems across state agencies and systems is a long-standing issue throughout state government that many groups are trying to address. For several years, DMHAS has been working through ADPC to improve data sharing, particularly concerning clinical behavioral health treatment information, among all state agencies serving individuals with substance abuse problems as well as the Judicial Branch. The two main barriers are: technical issues related to interoperability of state automated systems; and administrative issues, which primarily concern privacy laws and differences in agency policies about informed consent and release of information.

The Alcohol and Drug Policy Council has been focusing on these issues and its latest report (December 2008) contains recommendations to improve information coordination, including development of an interagency Memorandum of Agreement that will facilitate sharing

of client-level information related to mental health and substance abuse treatment. The council report also outlines steps for technological improvements to promote sharing of treatment information among criminal justice and health care agencies.

The committee believes the council's data sharing proposals are effective ways to coordinate information all agencies need for better treatment planning, service delivery, and outcome monitoring. Implementation should be made a priority by DMHAS, as co-chair of ADPC and the state's lead agency for substance abuse.

In regard to resources for data analysis, the committee found there is little internal capacity for data analysis within any of the three agencies that fund and provide substance abuse treatment at present. As noted above, DMHAS and CSSD have only small numbers of employees allocated to research and evaluation for all programs and services they fund while DOC has no staff solely dedicated to this function.

In addition, the body of research about state treatment programs and services all three agencies are producing is not being brought together and reviewed as a whole. As a result, *DMHAS, as lead agency, is losing opportunities to identify patterns and trends about treatment outcomes, as well as missing chances to share research resources and potentially avoid duplication of effort*.

*The committee found there is a general lack of public information on what impact the treatment system is having on the state's substance abuse problem*s. The current biennial report is the department's best effort at systemwide assessment of treatment outcomes but its value to informing policy and funding decisions is limited by its current scope and timeframe. At this time, DMHAS does not produce any type of "report card" information regarding the state treatment system.

As a SAMHSA technical assistance document notes, report cards are a way to present systematically organized data on standardized measures that are associated with specified standards and goals. Increasingly, private organizations and state agencies are using them to examine individual program as well as systemwide performance. They allow managers, policymakers, consumers, and the general public examine and compare information about key outcomes, determine whether programs and systems are meeting goals, and identify unmet needs as well as areas for improvement.

Producing reports cards can require significant investment in the infrastructure necessary to collect standardized, reliable information on outcomes. DMHAS has a strong foundation for a report card through its current automated data systems (e.g., SATIS and the GABHP system). In addition, the commissioner recently established an internal workgroup to develop and implement a strategic process for: defining organizational goals and direction; evaluating performance and outcomes; and communicating strategic initiatives to internal and external stakeholders. Developing and implementing a report card for the state substance abuse treatment system could be a task for this group. The workgroup also could have primary responsibility for carrying out the strategic planning process recommended above.

Finally, the department should be using the considerable data produced about clients and services to track more than program-specific or individual treatment effectiveness. It needs to aggregate available information to identify where there are strengths and weaknesses across levels of care and client populations.

When DMHAS has used performance and outcome information to inform policy and resource allocation decisions, results have been impressive. One example is the department's Opiate Agonist Treatment Protocol (OATP) initiative, a program that identifies opiate-addicted clients with multiple admissions to expensive residential detoxification programs and helps connect them with a continuum of lower intensity, and less costly, treatment and recovery support services. Agency analysis of OATP results shows the program addresses both ineffective treatment practices and inefficient uses of state resources.

For all of the reasons outlined above, efforts like OATP tend to be special projects rather than routine operating procedure. The committee believes that DMHAS, as lead substance abuse agency, should be collecting, monitoring, and reporting data on the effectiveness of the publicly funded treatment system on a regular basis. It also should be actively researching and promoting consistent best practices across agencies and throughout the system. Specifically, the department should be:

- tracking performance measures and outcomes for the overall system and its component parts (e.g., the state-operated and state funded treatment programs, all levels of care, and recovery support services), as well as monitoring individual client outcomes;
- reporting to policymakers, stakeholders, and the general public on systemwide and individual provider performance on a regular basis; and
- ensuring adequate internal and external capacity, including good quality data, for research and evaluation of treatment effectiveness.

Therefore, the program review committee recommends the following:

53) The statutes shall be amended to establish clearly that DMHAS is the state lead agency for substance abuse.

54) DMHAS should create and lead an interagency workgroup, composed of its own staff responsible for fiscal, contracting, and provider monitoring functions, as well as staff from other state agencies that fund and/or oversee substance abuse treatment services, including CSSD, DOC, and DPH, to study and address such matters as:

- **rules and regulations that are at odds with best care practices (e.g., appointments on separate days) and needless duplication of effort (e.g., repetitive financial forms);**

- **a standard plan of care so no matter what "door" a person comes in for treatment, there will be a consistent approach to developing the care plan, each plan will address a full continuum of services (from detoxification, if needed, to aftercare), and it will follow the client through the publicly funded system;**

- **better sharing of data, including regular distribution of DMHAS monthly and semi annual provider performance reports and profiles to CSSD and DOC; and**

- **ways to track and report on connection to services and treatment outcomes for DOC and CSSD clients with substance use disorders following discharge from the criminal justice system.**

55) DMHAS should begin working closely with the Department of Public Health to have updated substance abuse treatment regulations and the new combined license for dual behavioral health care providers in place by July 1, 2010.

56) The department also should conduct, with assistance from DOC and CSSD, a formal analysis of the costs and benefits of the collaborative contracting project to determine its impact on: standardizing rates paid by participating agencies; reducing administrative expenses of providers; and improving access to, and utilization of, available residential treatment resources.

57) DMHAS should restructure its existing staff resources allocated to planning, monitoring, and evaluation to create a centralized unit responsible for comprehensive strategic planning and quality improvement. It should also serve as the department's best practices unit, identifying effective treatment approaches and performing a clearinghouse function on policies, programs, and activities followed by Connecticut programs with good outcomes. Further, it should be a central repository for all state agency internal and external research products on treatment effectiveness.

58) Finally, the department shall prepare a "report card" for the publicly funded substance abuse treatment system that addresses, but is not limited to, the following areas: access to treatment; quality and appropriateness of treatment; treatment outcomes, including measures of abstinence and reduced substance use, as well as quality of life improvements related to employment, living arrangement, criminal justice involvement, and family and community support; and client satisfaction. At a minimum, the report card should be posted on the agency website and included in the department's biennial report.

APPENDICES

Appendix A
Federal and State Substance Abuse Treatment Information Systems

TEDS: Since 1996, the federal government has required states to report to SAMHSA each year standardized demographic and substance abuse characteristic data for substance abuse treatment admissions and discharges. The resulting Treatment Episode Data Set (TEDS) provides admission-based information about services and clients treated at licensed, certified or state-operated treatment facilities on a national and state-by-state basis over time.*

TEDS does not contain all admissions to substance abuse treatment but, in general, all facilities in the country that receive any state alcohol or drug agency funds (including federal grant funds) report to the system through their state substance abuse agency. (DMHAS submits data for Connecticut and provides information all state-operated programs and all licensed programs regardless of their funding status.) The most recent system data on admissions are for 2006 and cover all states; corresponding discharge data are available for 2005 and only represent 34 states at this time.

N-SSATS: On an annual basis, SAMHSA conducts the National Survey of Substance Abuse Treatment Services (N-SSATS), which collects data on the location, characteristics, and use of alcohol and drug treatment facilities and programs in each state and other U.S. jurisdictions. The survey covers all known public and private facilities and asks for information on services offered and clients in treatment as of a specific point in time (i.e., the last business day in March).

The most recent nationally compiled survey data are from 2003 but some information for 2006 is available for individual states, including Connecticut. The N-SSATS profile information for Connecticut substance abuse treatment facilities was presented in Chapter II of this report (Connecticut Substance Abuse Treatment System).

SATIS: DMHAS has established uniform procedures and policies for collecting, managing, and evaluating data related to substance abuse treatment programs operated or funded by the state and developed an interagency computerized database known as the Substance Abuse Treatment Information System (SATIS). Currently, the department is working in collaboration with eight other state agencies, the Office of Policy and Management, and the Judicial Branch to link data systems, comply with all client confidentiality requirements, and compile standardized information on substance use, abuse, and program effectiveness.

SATIS includes admission and discharge information from all substance abuse treatment programs licensed by the state Department of Public Health and from the state treatment programs operated by DMHAS and the Department of Correction. The system does not include information on persons served by: general hospitals, unless the treatment is funded by DMHAS; private practitioners (e.g., physicians, psychologists, and licensed counselors); or the Veterans' Administration.

* Admissions do not represent individuals so, for example, a person admitted to treatment twice within a calendar year would be counted as two admissions.

Source: PRI staff analysis

Appendix B. DMHAS Regional Structure

DMHAS Regions	Regional Mental Health Boards (RMHBs) -- 5	Local Mental Health Authorities (LMHAs) -- 14 statewide; 6 State-Operated, 8 Private Nonprofits (PNPs)	Catchment Area Councils (Mental Health CACs) -- 23 total	Regional Planning and Action Councils (Substance Abuse RACs) -- 14 statewide
I: Southwest (14 towns)	Office location: Norwalk	• Southwest CT Mental Health System (State), which includes 2 area programs: o F.S. DuBois Center o Greater Bridgeport Community Mental Health Center	• 1, 2 • 3, 4	• Lower Fairfield County Communities in Action • Mid Fairfield Substance Abuse Coalition • Regional Youth/Adult Substance Abuse Project
II: South Central (36 towns)	Office location: Middletown	• Bridges (PNP) • Connecticut Mental Health Center (State) • Harbor Health Services (PNP) • River Valley Services (State) • Rushford Center (PNP) • Valley Mental Health Center/Birmingham Group Health Services (PNP)	• 6 • 7 • 8 • 10 • 9 • 5	• Meriden and Wallingford Substance Abuse Council, Inc. • Middlesex County Substance Abuse Action Council • South Central CT RAC • Valley Substance Abuse Action Council
III: Eastern (39 towns)	Office location: Norwich	• Southeastern Mental Health Authority (State) • United Services (PNP)	• 11, 12 • 13, 14	• Citizen's Task Force on Addictions • Northeast Communities Against Substance Abuse
IV: North Central (38 towns)	Office location: Newington	• Capitol Region Mental Health Center (State) • Community Health Resources (PNP), which includes 2 area programs: o Genesis Center o North Central Counseling Service • Intercommunity Mental Health Group (PNP) • Community Mental Health Affiliates (PNP)	• 18, 23 • 15 • 17 • 16 • 19	• Capitol Area Substance Abuse Council • East of the River Action for Substance Abuse Elimination • Substance Abuse Action Council of Central CT, Inc.
V: Northwest (42 towns)	Office location: Waterbury	• Western CT Mental Health Network (State), which includes 3 area programs: o Danbury Mental Health Authority o Greater Waterbury Mental Health Authority o Northwest Mental Health Authority	• 21 • 20 • 22	• Central Naugatuck Valley Regional Action Council • Housatonic Valley Coalition Against Substance Abuse

APPENDIX C. DMHAS FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS (2008)				
Program Focus/ Collaboration	**Program Description**	**Target Population**	**Program Locations**	**Program Capacity/ Individuals Served**
DIVERSION/WITH LAW ENFORCEMENT				
Crisis Intervention Teams (CIT)	• Trained clinicians work with trained police officers to provide joint response or follow-up to crisis calls involving persons with apparent behavioral health disorders • Clinicians evaluate and make recommendations • Refer to appropriate treatment rather than arrest	Persons in psychiatric crisis encountered by police	DMHAS CIT clinicians serve 8 areas (Bridgeport, Groton, Hartford, New Haven, Norwich/New London, Waterbury, West Haven, Stamford) 21 police departments have CIT policy and sufficient number of CIT-trained officers to provide effective response	In FY 07, 4 DMHAS CIT clinicians assisted with 1,700 police cases (Expanding to 7 DMHAS CIT clinicians in FY 09)
DIVERSION/WITH CSSD				
Pretrial Alcohol Education System (PAES)	• Contracted program overseen by DMHAS to divert from trial certain persons arrested for Operating under the Influence (OUI) & referred by courts • Clinical evaluation to determine recommended service level • Four levels of service: 1) Evaluation 2) Level 1 Groups (intervention) 3) Level 2 Groups (intensive intervention) 4) Treatment (minimum of 12 therapy sessions)	First time offenders arrested for OUI (or offenders with prior arrest >10 years ago with no intervening arrests or convictions)	Statewide; 11 providers in 23 communities (Level 1&2 groups)	Total Served FY 07: • Evaluation: 8,260 • Level 1: 3,780 • Level 2: 3,213 • Treatment: 200
Pretrial Drug Education Program (PDEP)	• Contracted program overseen by DMHAS to divert certain persons arrested for drug possession from trial referred by courts • Evaluation by substance abuse professional and 12 hours of intervention (group) programming –"Drug Education Program" (DEP)	First-time offenders arrested for possession of drugs and/or paraphernalia	Statewide; 11 providers, 23 communities	Total Served FY 07: • Evaluation: 4,302 • DEP Groups: 4,112

APPENDIX C. DMHAS FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS (2008)				
Program Focus/ Collaboration	**Program Description**	**Target Population**	**Program Locations**	**Program Capacity/ Individuals Served**
Community Service Labor Program (CSLP)	• Certain persons arrested for drug possession found eligible by CSSD for diversion program of 14 to 30 days of community service also required to complete drug education program • DMHAS, under MOU with Judicial Branch, allows CSLP participants to use PDEP program services to met drug education requirement	Persons charged with possession of illegal drugs and/or paraphernalia	(same as PDEP)	(included in PDEP statistics)
DIVERSION/ & EARLIER RELEASE/ WITH CSSD & DOC				
Community Recovery, Engagement Support, and Treatment Center (CREST)	• Intensive day reporting program for persons diverted or released from incarceration, or on parole/probation and at risk of incarceration • Provides daily monitoring, structured skill building, recovery supports • Outpatient treatment services provided by DMHAS-operated CMHC	Persons with serious mental illness or co-occurring disorders, at pre-trial stage or on probation or parole	New Haven	Began accepting clients in December 2007 Center capacity: up to 30 individuals
Jail Diversion	• Facilitate access to appropriate treatment as alternative to incarceration • Provide court-based assessment, referral, and linkage to community treatment services • Inform courts of treatment compliance • Provide clinical information to jails for defendants detained on bond	Persons with serious mental illness or co-occurring disorders arrested on minor offenses	Statewide	Screen approximately 4500 clients per year and of these about 1500 are diverted by the court; consultation on approx 10,000 cases per year
Jail Diversion-Women (JDW)	• Trauma-informed diversion efforts for female offenders to reduce incarceration and future arrests • Pre-release assessment and immediate access to comprehensive, trauma-informed care • Treatment for trauma, mental illness, substance abuse plus community supports	Women with history of trauma, at risk of incarceration, referred by courts, probation, or parole	New Britain/Bristol New Haven (With new federal grant, see JDT, below, Hartford location expanded to serve men as well as women)	New Haven began accepting clients in January 2008 Capacity: 50 women for each program, annually

APPENDIX C. DMHAS FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS (2008)				
Program Focus/ Collaboration	**Program Description**	**Target Population**	**Program Locations**	**Program Capacity/ Individuals Served**
Jail Diversion - Trauma (JDT)	• Trauma-informed diversion efforts for male and female offenders to reduce incarceration and future arrests • Services similar to JDW, see above	Women and men with history of trauma, at risk of incarceration, referred by courts, probation, or parole	Hartford area	Annual Capacity: 50 clients per year
Alternative Drug Intervention (ADI)	• 3- to 6-month treatment program provided as alternative to incarceration • Intensive outpatient substance abuse treatment provided • Also intensive case management, basic needs, employment & education supports, linkage to 12-Step groups	Persons with substance use disorders, at pre-trial stage	New Haven	Program annual capacity: approx. 150 - 200 Total Served FY 08: 157
Advanced Supervision and Intervention Support Team (ASIST)	• Coordinate behavioral health services with supervision and skills training provided by DMHAS clinician at Alternative to Incarceration Centers to make AICs accessible to persons with moderate to serious psychiatric/co-occurring disorders • DMHAS clinician provides case management • Mental health and substance abuse recovery services provided by LMHAs for persons with serious mental illness and by CSSD contractors for others	Persons with moderate to serious psychiatric disorders who may or may not have substance use disorders at risk of incarceration; referred by court, DOC facility, probation, or parole	Bridgeport Hartford Middletown New Britain New Haven New London Waterbury	Began accepting clients in some locations in November 2007; Projected annual capacity: 315- 420
REENTRY/ WITH DOC & CSSD				
Connecticut Offender Reentry Program (CORP)	• Prior to discharge, DMHAS staff provide comprehensive assessment and skills building group twice per week in the DOC facility for 6-12 months prior to release, and develop comprehensive discharge plan • After discharge, appropriate LMHA provides continuing treatment and support services	Sentenced inmates with serious mental illness or co-occurring disorders returning to community after extended period of incarceration	In 3 DOC facilities (Garner CI, Osborn CI, and York CI) For inmates returning to Bridgeport, Hartford, and New Haven (expanding to Waterbury and Norwich/New London in FY 09)	Total served annually: approx. 60

APPENDIX C. DMHAS FORENSIC SERVICES DIVISION SPECIAL PROGRAMS WITH SUBSTANCE ABUSE TREATMENT COMPONENTS (2008)				
Program Focus/ Collaboration	**Program Description**	**Target Population**	**Program Locations**	**Program Capacity/ Individuals Served**
Transitional Case Management (TCM)	• Case management by DMHAS staff (i.e., "transitions manager") to support recovery-oriented reentry to community • Works with inmates in DOC institutions for 3-4 months prior to release for engagement and to develop a comprehensive discharge plan • For 3-5 months after release provide substance abuse treatment and case management, and collaborate with parole and CSSD to plan and provide care services • Community service providers given early notice of inmate's potential discharge	Inmates with significant histories of substance abuse transitioning to community	Inmates returning to Hartford and Waterbury Expanding to serve persons returning to Norwich/New London and New Britain/Bristol in FY 09	FY 07 - TCM served 110 individuals, transitioned 80 to the community
Criminal Justice Interagency Referral Program	• Comprehensive DOC-DMHAS referral program • 3 to 6 months prior to release from DOC, appropriate LHMA meets with inmate to plan/arrange needed community services • On-going interagency communication to coordinate care, resolve any system issues	Persons with severe psychiatric disabilities transitioning from correctional facility to community. For those individuals who are not served by the CORP program.	Statewide	Served annually: 220-270
Sources of Data: DMHAS and CSSD				

Appendix D.

GABHP Utilization Mangement Model: Levels of Care for Substance Abuse Treatment

LEVEL OF CARE	Code	Initial Length of Stay	Continued Length of Stay
Ambulatory			
Outpatient	SA I.1	13 visits	Up to 16 visits
Outpatient - Methadone Detox.	SA I.2	Up to 21 days	Up to 21 days
Methadone Maintenance	SA I.3	Up to 26 wks	Up to 26 wks
Intensive Outpatient	SA II.1	Up to 10 visits	Up to 7 visits
Day/Evening Treatment	SA II-5	Up to 5 visits	Up to 5 visits
Observation (23-hour bed)	SA II.7	Up to 23 hours	None
Residential			
Transitional Care/Halfway House	SA III-1	Up to 15 days	Up to 45 days
Long-Term Care	SA III-3	Up to 30 days	Up to 60 days
Residential Treatment - Intermediate/Long-Term	SA III-5	Up to 20 days	Up to 45 days
Intensive Residential Treatment	SA III.7R SA III.8	Up to 10 days	Up to 10 days
Detoxification			
Detox. - Ambulatory	SA I.D	Up to 7 days	Up to 7 days
Detox.- Ambulatory with on-site monitoring	SA II.D	Up to 7 days	Up to 7 days
Detox - Residential Medically Monitored	SA III.7D	Up to 3 days*	Up to 2 days
Detox - Inpatient Medically Managed	SA IV.2D	Up to 3 days*	Up to 2 days

* Up to 3 days for alcohol or alcohol & cocaine detoxification: all other substances up to 5 days

Source of data: DMHAS Utilization Management Model for GABHP

Appendix E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component (2008)

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
Adult Behavioral Health Services (ABHS)	• Substance abuse assessment • Group and intensive outpatient substance abuse treatment • Group anger management • Mental health evaluation and treatment • (Each location may provide all or any of the services listed) • • Fees = Sliding scale fee	Clients referred by Adult Intake, Assessment and Referral or Supervision offices. Referrals are based on outputs of LSI-R and ASUS-R, court ordered conditions, and presenting issues /problems at time of supervision.	Varies by service. Services are based on individual need generally: Sub Abuse Eval. ~ 1 to 2 sessions. Sub Abuse Group ~ 12 sessions 1x wk. Intensive Out Patient tmt. 3 to 4 times per week for 4 to 6 weeks. Anger anagement.~ 12 sessions. Mental Health Eval. 1 to 2 sessions. Mental Health Treatment: individualized based on presenting issues.	Yes	Eastern	12	No specific slot number	1,654
					North Central	5	No specific slot number	2,348
					Northwest	10	No specific slot number	2,815
					Southwest	5	No specific slot number	1,549
					South Central	5	No specific slot number	2,002
Alternative Incarceration Centers (AIC)	• Intake, assessment, for risk and need • Substance abuse assessment • Case management • Group interventions (including substance abuse) • Community service	Accused and sentenced offenders age 16 years and older Referrals are based on outputs of LSI-R and ASUS-R, court ordered conditions, and presenting problems at	Average length of stay in program is 3 to 4 months. Case management frequency is based on risk level of client ~ minimally 2 times per month. Sub. Abuse group is	Yes	Eastern	4	No specific slot number	1,272
					North Central	6	Hartford - 30 beds - (the only AIC in region with beds). Other AICs no specific slot	2,207

Appendix E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component (2008)

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
	restitution • Pre-trial urinalysis testing • Referral to community and job development • Note: Some transitional housing may be available. This housing component of the AICs generally do not have any services on-site. Services are conducted at the AIC.	time of supervision. Pre-trial referrals receive supervision and services to ensure their appearance in court; program is used as a tool in reducing prison overcrowding for pre-trial population.	12 sessions run 2 times per week. Cog. Skills group is 14 sessions run 2 times per week. Urines are random, minimally 2 times per month when ordered by referral source. Employment group ~ skills component is 4 sessions, graduated clients stay in group until job is obtained.				number.	
					Northwest	4	Torrington and Waterbury – 60 beds – Other AICs no specific slot number	1,960
					Southwest	3	No specific slot numbers	1,577
					South Central	3	New Haven – 22 beds – Other AICs no specific slot number	1,651
Adult Risk Reduction Centers (ARRC)	• Anger management • Substance abuse treatment • Cognitive self change • Motivational enhancement training • Cognitive restructuring • Reasoning and	High risk and need sentenced offenders	Typically 6 to 9 months	Yes	Eastern	0	0	
					North Central	1	75 slots	134
					Northwest	0	0	
					Southwest	0	0	

Appendix E

Table 1. CSSD Adult Programs: Non-Residential Programs with a Substance Abuse Treatment Component (2008)

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
	rehabilitation • Seeking safety ~trauma • Moving on				South Central	0	0	
Drug Intervention Program (DIP)	Program conducts clinical evaluations, prepares treatment plans, and delivers a full continuum of substance abuse treatment, case management, residential (long and short term) and support services	Criteria include: • Non violent criminal history • Referral by court • Drug dependent • • Clients may be identified at arraignment, prior to sentencing and not incarcerated, or arrested and in jail awaiting trial, or on probation and non compliant with treatment stipulations or for committing new crimes connected to substance abuse problems or arrested for a violation of probation	Varies depending on court order, assessed level of care, and accomplishments made in treatment.	Yes	Eastern	2	30 slots	35
					North Central	0	0	0
					Northwest	0	0	0
					Southwest	4	Bridgeport 45 slots and 7 beds Stamford 3 beds	89
					South Central	1	60 slots	43

Appendix E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
Residential Services – Halfway House (Union House)	Provides pretrial supervision services for accused individuals and work release supervision for sentenced (probation and parole) offenders. Other services include interim treatment for those awaiting availability of inpatient treatment	Male and female offenders age 16 and above in need of residential supervision in lieu of incarceration	Varies	No	Statewide	1	36 beds	140
Residential Services - Medical Detoxification	Community – based, residential program. Services include medically managed or medically supervised intensive substance abuse detoxification	Pre-trial, court sentenced, alternative to violation of probation and parole: males and females age 18 and above	3 to 28 days. Detox is 3 -4 days.	Yes	Statewide	1	5 beds	n/a

Appendix E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
Residential Services – Project Green	Community –based residential program. Services include but are not limited to community services, substance abuse education and treatment, employment readiness, case management, resources management, and life skills training	Pre-trial and sentenced males and females age 16 and above who are addicted/dependent on drugs and/or alcohol and are capable of performing intensive community service labor. (Male only in New Haven)	4 to 6 months	Yes	Statewide	2	49 beds	188

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
Residential Services – Substance Abuse Short Term and Intermediate	Community-based residential program. The following services are provided: • Substance abuse treatment • Individual and group counseling • Educational/ vocational skills development • Crisis intervention • Health intervention • Independent living skills • Family counseling • Access to recreational opportunities • Pre-release counseling • Aftercare/discharge planning Includes CVH and Blue Hills which are state run facilities. (195 clients)	Male and female (age 18 and above) pre-trial and sentenced offenders and alterative to probation/parole violation cases. Individuals must be drug and/or alcohol dependent. (16 and 17 year olds may be accepted at some locations)	3 to 6 months	Yes	Statewide	0	327 beds	1,169

Appendix E

Table 2. CSSD Adult Programs: Residential Programs with a Substance Abuse Treatment Component

Program Type	Services/Program Description	Target Population	Treatment Timeframe	Research or Evidence Based Program	Region,Locations,Capacity			Number Served FY 08 (except where noted)
Residential Services – Substance Abuse Long Term	Community-based residential program. The services include all the services provided under intermediate above but for a longer duration.	Admission is based on multiple previous episodes for one facility. All other programs conduct an evaluation to determine level of care. Client's progression through treatment is individualized.	6 to 12 months One program is 6-12 months; three programs are 6-9 months.	Yes	Statewide		74 beds	220
Residential Services – Youthful Offender	Community-based residential program. Services include: • Academic/ vocational education • Life skills training • Substance abuse education and treatment • Case management • Community service participation • Recreation and physical fitness • Family counseling and support • Community reintegration	Sentenced male offenders age 18-21	4 to 6 months	Yes	Statewide	1	24	72

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	**Services/Program Description**	**Target Population**	**Treatment Timeframe**	**Research or Evidence Based Program**	**Region, Locations, Capacity**			**Number Served Annually FY 08 (except where noted)**
Domestic Violence – Evolve	A 52 week cognitive/ behavioral intensive program designed for high risk offenders. Focus is on the effects of violence on victims and children, behavior change, interrelation and communication skill building, responsible parenting and substance abuse. (12 sessions related to substance abuse).	Male offenders involved in a family violence offense as referred by the criminal court, following a guilty plea	52 weeks	Yes	Eastern	0	0	FY 07: 412
					North Central	0	0	
					Northwest	1	288 units	
					Southwest	1	576 units	
					South Central	1	480 units	
Domestic Violence – Explore	A 26 week cognitive/ behavioral intervention focused on educating repeat offenders about the impact and harmful effects of violence on victims and children; emphasis on establishing inter-personal skills to develop violence-free relationships. Six sessions focus on the role of substance abuse in violent behavior.	Male offenders involved in a family violence offense as referred by the criminal court, following a guilty plea.	26 weeks	Yes	Eastern	3	352 units	FY 07: 641
					North Central	2	506 units	
					Northwest	1	46 units	
					Southwest	3	230 units	

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	**Services/Program Description**	**Target Population**	**Treatment Timeframe**	**Research or Evidence Based Program**	**Region, Locations, Capacity**			**Number Served Annually FY 08 (except where noted)**
	(8 sessions related to substance abuse).				South Central	2	138 units	
Bridgeport Domestic Violence Intervention Services	Services include: • Individual and group counseling for men and women not eligible for Family Violence Education Program • Conflict management groups • Adolescent group counseling • Substance abuse evaluation and treatment cognitive based treatment (10 sessions) • Psychological testing • Parenting skills	Persons involved in court proceedings after an arrest for a domestic violence offense.	Varies	Yes	Eastern	0	0	
					North Central	0	0	
					Northwest	0	0	
					Southwest			138
					South Central	0	0	
Family Violence Education	Cognitive intervention focused on educating offenders on the impact of violence on	Persons charged with family violence crimes.	9 weeks	Yes	Eastern	4	26 units	FY 07: 3,885

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	**Services/Program Description**	**Target Population**	**Treatment Timeframe**	**Research or Evidence Based Program**	**Region, Locations, Capacity**			**Number Served Annually FY 08 (except where noted)**
Program	relationships, developing an understanding of its harmful effects and providing offenders with the building blocks of interpersonal skills to develop violence-free relationships. Consists of 10 weekly classes at 1.5 hours per class. Two sessions focus on substance abuse.				North Central	3	54 units	
					Northwest	3	25 units	
					Southwest	4	38 units	
					South Central	3	40 units	
Gender Specific Programming for Females	Community-based program provides services for women that address the risks and needs of women offenders. Services include: • Trauma services related to sexual/ physical/ and mental abuse • Substance abuse treatment • Parenting • Cognitive skill building • Education and employment	Accused and sentenced female offenders age 16 years and older	Varies	Yes	Eastern	0	0	
					North Central	0	0	
					Northwest	0	0	

Table 3. CSSD Adult Programs: Special Programs with a Substance Abuse Treatment Component								
Program Type	**Services/Program Description**	**Target Population**	**Treatment Timeframe**	**Research or Evidence Based Program**	**Region, Locations, Capacity**			**Number Served Annually FY 08 (except where noted)**
	services				Southwest	1	75 Slots	236
					South Central	0	0	
Women and Children Services	Comprehensive community based substance abuse, dual diagnosis, and rehabilitation treatment facility	Pre-trial or sentenced, substance abusing female offenders, age 16 and above	4-12 months	Yes	Eastern	0	0	
					North Central	1	21 beds	60
					Northwest	1	12 beds	30
					Southwest	0	0	
					South Central	1	15 beds	35
Latino Youth Offender Services	Cognitive-based approach which services include the development of educational, economic, social, and community resources through intensive case management, substance abuse treatment services, and community service.	Latino offenders age 16-23	Up to 6 months	Yes	Eastern	0	0	
					North Central	0	0	
					Northwest	0	0	
					Southwest	0	0	
					South Central	1	30 slots	68
Source of Data: CSSD								

Appendix F. Department of Correction Institutional Substance Abuse Programs by Facility (2008)												
Facility Name	**Location**	**Level**	**Population (2007)**	**Assessment & Orientation**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Aftercare**	**Peer Mentor Program**	**Alcohol Anon. (AA)**	**Narc. Anon. (NA)**
Bergin	Storrs	Low	1,084		x		x		x		x	x
Bridgeport	Bridgeport	High	941	x	x	x					x	x
Brooklyn	Brooklyn	Med	455			x			x	x	x	x
Cheshire	Cheshire	High	1,336						x	x	x	x
Corrigan-Radgowski	Uncasville	Med & High	1,481	x	x	x				x	x	x
Enfield	Enfield	Med	725			x			x	x	x	x
Garner	Newtown	High	554								x	x
Gates	Niantic	Low	1,021			x	x		x	x	x	x
Hartford	Hartford	High	957	x	x						x	x
MacDougall-Walker	Suffield	High & Max	2,131	x	x	x			x	x	x	x
Manson[51]	Cheshire	High	680	x	x	x		x	x	x	x	x
New Haven	New Haven	High	834	x	x						x	x
Northern	Somers	Max	453								x	
Osborn	Somers	Med	1,929			x		x	x	x	x	x
Robinson	Enfield	Med	1,218					x	x	x	x	x
Webster	Cheshire	Low	583						x	x	x	x
Willard-Cybulski	Enfield	Med	1,099			x			x	x	x	x
York[52]	Niantic	Low to Max	1,408	x	x	x		x	x	x	x	x
Total			18,889	7	8	10	2	4	12	12	18	17
Source of Data: DOC												

[51] Manson Youth Institution is a facility for young offenders between the ages of 14 and 21.
[52] York Correctional Institution is the only women's prison in Connecticut.

APPENDIX G

Agency Responses

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

M. JODI RELL
GOVERNOR

THOMAS A. KIRK, JR., PH.D.
COMMISSIONER

Memorandum:

TO: Program Review and Investigations Committee

FROM: Thomas A. Kirk, Jr., Ph.D., Commissioner

DATE: February 23, 2009

SUBJECT: DMHAS Response to Recommendations of the Program Review and Investigations Committee related to their 2008 Study, ***"Substance Abuse Treatment for Adults"***

Introduction:

In 2008, the Program Review and Investigation (PRI) Committee conducted a study entitled, ***"Substance Abuse Treatment for Adults"*** and issued recommendations on December 17, 2008. This is the response prepared by the Department of Mental Health and Addiction Services (DMHAS), broken out by recommendation. DMHAS wishes to share with members of the General Assembly, the PRI Committee and other stakeholders its understanding of the intent of the recommendations and the feasibility of their implementation.

In our analysis of the Committee's recommendations, several factors were considered. First, was there a full and accurate understanding of DMHAS' current status regarding the recommended process, activity or procedure? If not, we have provided clarifying remarks meant to enhance the Committee's recommendation. Second, was the recommendation likely to result in improved efficiency and/or effectiveness of substance abuse services? In that portion of our analysis, the burden on the provider system was carefully considered, as were the Department's current resources for adequate implementation of the recommendation.

In its review, the Department found that several of the PRI recommendations are already under development or in some stage of implementation within DMHAS. Some recommendations could be accomplished within existing resources, while others might be carried out through some refocusing of resources or efforts. Following our review, we have made notations to each recommendations as follows: (1) items which meet the above criteria are shown as **"supported"**; (2) in other instances, we **agree with the general intent** of the recommendation, but **note varying degrees of operational and/or significant budgetary implications, if implemented as recommended,** or (3) in the case of those recommendations that the Department felt were arrived at without full knowledge or understanding of the current status or circumstance, we indicate that we are **unable to support** the recommendation and include an explanation as to why.

The Department offers the following comments in the spirit of mutual interest in continuing to deliver the quality substance abuse treatment that Connecticut has become known for providing. DMHAS is seen by many (e.g., the federal Center for Substance Abuse Services, the National Association of State Alcohol and Drug Abuse Directors, etc.) as a national forerunner in the development of standards for recovery-oriented and person-centered services, and integrated care for persons with co-occurring substance use disorders and mental illness. Indeed, many of the PRI recommendations support the Department's strategic vision of ***Healthy People, Healthy Communities. Let's Make It Happen!*** Inherent in that vision is a strong emphasis on health promotion and prevention services, treatment access, a full continuum of quality and recovery support services, and system accountability.

- **Recommendation 1: DMHAS shall assess demand for substance abuse treatment services on a periodic basis through the coordination of wait list information or other methods to identify gaps and barriers to treatment services and report the results in the department's biennial report.**

The Department **supports the spirit** of this recommendation, but **offers an alternative approach**. DMHAS currently assesses treatment demand in several significant ways. One such method is through state estimates provided in the National Survey on Drug Use and Health (NSDUH) conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). While DMHAS has conducted two state-specific surveys in the past, due to the significant cost of administering such surveys, the agency now utilizes the NSDUH, which contains information on barriers to treatment along with other measures of met and unmet need and demand.

In addition to the results of the NSDUH, DMHAS has utilized a Priority Services Setting Process since 2001 to determine unmet needs and assess emerging issues by obtaining feedback from local and regional stake-holders. In addition, these stakeholders recommend service priorities to the Department for consideration in development of our biennial budget. Progress made over the ensuing year is monitored at the local and regional levels. This process has proven valuable in understanding how responsive the DMHAS behavioral health care system is to those in need.

Specific to the PRI recommendation, it should be noted that the reliability and accuracy of waiting lists to measure treatment demand is questioned by many in the addictions field. Measuring treatment demand is complex and depends upon a number of factors which can include the person's behavior in relation to his or her substance use, the stage of the substance use disorder, the cost for treatment, the individual's income and education level, and other market forces and personal characteristics (see "*Health Services Utilization by Individuals with Substance Abuse and Mental Disorders,*" SAMHSA 2004). Furthermore, our operational experience has shown that persons register for multiple programs in hopes of accessing the first available care slot. Thus, many individuals whose names appear on waiting lists for programs have already begun receiving services at another facility or level of care. Therefore, use of waiting list data may not result in a significant improvement in treatment service planning, given the time and resources it will take, and the reliability of the data.

An alternative approach that would provide practical utility while minimizing the burden of data reporting would be a "point-in-time survey" of treatment programs. Using a web-based survey application, information could be gathered on the number of persons attempting to access treatment services across the state on a specific day. This information, if tied to the National Substance Abuse Treatment Services Survey (N-SATSS) which captures the number of persons actually in treatment on a given day, could be a strong measure of unmet demand.

- **Recommendation 2: DMHAS shall determine a method to track the availability of substance abuse treatment services and provide that information to the public through websites, a toll-free hotline, through the statewide human service help line, 2-1-1 (formally Infoline), or other similar mechanisms.**

DMHAS **agrees with the intent of this recommendation; however, its implementation, as recommended, has significant budgetary implications**. The Department already collects census (i.e., current capacity and utilization) information from its funded addiction services residential treatment providers and Recovery Houses on a daily basis. This information is sent electronically to an extensive list of state agencies, community referral organizations, hospitals, and others interested in accessing residential substance abuse treatment services. The census report provides a point-in-time picture of bed availability in a very fluid system where persons are admitted and discharged throughout the course of each day. In addition, DMHAS maintains a "Service Directory" available to the public that contains information— such as the location of provider programs, types of services provided, contact numbers, and special populations served —for all behavioral health service providers in the state. We also contract with Advanced Behavioral Health to operate a "Consumer Line" that effectively assists individuals with referrals to treatment services, and we support a few small area "access lines." If, as recommended, a statewide toll-free treatment access line were to be implemented, we would first weigh reallocating all current support of the aforementioned lines. Then we would go statewide, listing not only DMHAS' funded service capacity, but also that of the Department of Correction and the Judicial Branch's Community Support Services Division. However, it must be noted that expansion to a staffed, well developed, full capacity and multiple-levels-of-care system would incur **substantial costs beyond the Department's current allocations**.

- **Recommendation 3: DMHAS shall develop and report on process measures in its biennial report that measure: (a) Time to receive SA services; and (b) Length of Treatment service episode (90 days).**

DMHAS agrees with the intent of this recommendation, with the caveat that there are significant fiscal implications referenced below. First, regarding measuring time to services, DMHAS fully understands the importance of having ready access to treatment services. Treatment engagement and retention have been, and continue to be, a Department priority. DMHAS has been participating with Brandeis University and other states in developing ways to measure these important indicators of system performance. We are also exploring, as part of our information system upgrade, the addition of a new data item — i.e., the client's first contact with program. With this in place, it will be possible to measure time to treatment, one indicator of system responsiveness, to demand for services. Analysis of time to treatment and access barriers could be the catalyst for appropriate program modifications, leading to improved access to services, while at the same time decreasing the number of clients who don't return ("no-shows") for their first clinical appointment. The new DMHAS information system currently in development, and expected to be completed by the winter of 2010, will be able to collect this information. Based on our experience with earlier system changes of a similar nature, it is anticipated that **there will be a significant cost to our contracted providers** to retool their information systems to collect new data items.

Secondly, DMHAS currently produces a report on substance abuse treatment episodes based upon a person's continuous treatment over several levels of care. Our Evaluation, Quality Management and Improvement (EQMI) Division is working on refining that report to show all discharges within a specified time frame and the length of time (e.g., 90 days or greater) that a client is involved in treatment. Once completed, this will be a major indicator of system quality, as it will reflect the degree of engagement and retention of a person in care as well as of sustained recovery orientation.

- **Recommendation 6: DMHAS should investigate— with CSSD, the DOC parole division, and DPH— the development of joint quality assurance and monitoring teams for substance abuse treatment facilities or of a common approach for reviewing and checking similar areas of concern and coordinating such review efforts. Either activity should include the development of a corrective action plan summary of compliance issues identified regarding substance abuse treatment providers and the sharing of that information among all agencies.**

DMHAS **supports** this recommendation. Through the current Collaborative Contracting Project, DMHAS, CSSD, and DOC have initiated common purchasing approaches, which include joint quality assurance and

monitoring of specific levels of care (i.e., substance abuse residential services). Discussions are currently underway to apply this collaborative approach across other substance abuse treatment levels of care, extending the Collaborative Contracting concept.

The Department of Public Health (DPH) is the state agency responsible for regulatory oversight of licensing for substance abuse treatment programs, while DMHAS focuses its monitoring activities on quality clinical care management and service delivery. DPH does have a process in place to share corrective action plans and summary of compliance issues for DMHAS-funded treatment programs with the Department.

- **Recommendation 9: DMHAS should compile and analyze information about provider substance use testing procedures, create a uniform policy, and ensure that regular testing is performed and that best practices are followed.**

DMHAS **supports** this recommendation as an important aspect of treatment for substance use disorders. The Department is accountable to guidelines set forth by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), DMHAS and DPH regulations and General Assistance Behavioral Health Program (GABHP) policies regarding drug testing by substance abuse treatment providers. At this time, compliance is conducted by DMHAS during routine on-site monitoring visits, and DPH does the same during their unannounced, on-site licensing visits. Those programs that have national accreditation (e.g., Joint Commission, Council on Accreditation of Rehabilitation Facilities - CARF) are also reviewed during unannounced site visits. Opioid treatment programs (OTPs) are also directly accountable to federal regulations (42 CFR part 8.12) for conducting more frequent drug screening. The Department will consider expansion of its current monitoring practice to encompass more treatment providers and compile information on current drug testing practices. DMHAS is also exploring with DPH the option of alternative, proven methods for drug screening (e.g., oral fluid testing). Based upon this information, DMHAS will investigate the development of a policy statement which is supported by documented best practices.

- **Recommendation 10: DMHAS shall establish a clear definition of research and evidence-based practices and develop a strategy to encourage the use of such practices for substance abuse assessments and treatment, including program fidelity checks and measuring the therapeutic alliance. The strategy shall be developed by January 1, 2010.**

DMHAS **agrees with the intent of the recommendation; however, implementation as recommended, has significant budgetary implications.**

A clear definition of evidence-based practices has been established by SAMHSA, i.e., *"Evidence-based practices are practices that have been tested employing specified scientific methods and shown to be safe, efficacious, and effective for most persons with a particular disorder or problem"*. Although DMHAS does not require the use of specific substance abuse assessment *instruments* across its service system, for the most part, DMHAS-funded providers are using validated substance abuse assessment instruments.

Relative to research and evidence-based practices, it is important to note that DMHAS has been very aggressive and highly successful during the last ten years in securing over $80 million in federal grants to develop and test "research and development" care strategies, outcome measures and delivery models related to substance use disorders. Often, academic and private non-profit providers have been partners in these projects. The findings from these initiatives continue to be progressively and incrementally embedded into the DMHAS private/public service system. A sample of these is reflected in descriptions below. Further, the second edition of ***"Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions"*** will be in print by early March. Developed by the Yale Program for Community Health in concert with DMHAS, it incorporates the 2005 Institute of Medicine recommendations for *Improving the Quality of Health Care for Mental Health and Substance Use Conditions* and meshes them with standards that DMHAS and its providers have adopted for gender- and trauma-informed care, cultural competence and co-occurring substance use/mental health treatment.

Partially stemming from the work noted above, DMHAS has taken significant and important steps to increase the use of evidence-based practices in the treatment of adults with substance use disorders or co-occurring substance use and mental health disorders. Examples of Department efforts to date include:

a. Providing training, technical assistance, and ongoing consultation to treatment providers to implement integrated substance abuse/mental health treatment models as part of a federally funded project. Also, DMHAS has introduced a Co-Occurring Training Academy through its existing Education and Training Program.
b. Supporting culturally appropriate and accessible methadone maintenance treatment services on a statewide basis.
c. Developing internal capacity for ongoing monitoring of evidence-based practices, such as Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT), through a National Institute on Drug Abuse (NIDA) grant.
d. Supporting ongoing training and technical assistance to treatment providers on evidence-based practices, such as Motivational Interviewing (MI), cultural competency, co-occurring disorders, trauma responsive care, and Cognitive Behavioral Therapy (CBT).
e. Implementing Matrix Intensive Outpatient Treatment, an evidence-based treatment model for methamphetamines and/or cocaine.
f. Promoting use of medication-assisted therapies such as buprenorphine/naloxone in ambulatory detoxification and chemical maintenance treatment for opioid dependence.

What some consider evidence-based practices are, at times, based upon less than robust research with actual target populations, and may not end up producing superior outcomes or value through return-on-investment (ROI) – independent of the degree of fidelity to a specific model. For this reason, DMHAS recommends EBPs be selected and implemented judiciously with specific populations. To be considered as part of any promotion of evidence-based practices are the **significant new resources that would be needed**— including training and technical consultation for service providers, measurement of program fidelity and therapeutic alliance, and continued support of the practice over time.

In the place of developing a separate operational strategy, DMHAS suggests including its current strategies for encouraging the use of research or evidence-based substance abuse treatment practices and measuring practice fidelity and therapeutic alliance within the PRI recommendation for development of a Substance Abuse Strategic Plan (see **Recommendation #23**).

- **<u>Recommendation 11:</u> DMHAS should collect and report data on the number of substance abuse clients who receive services to support their recovery and any related outcome information.**

The Department **agrees with the intent of the recommendation, but there may be budgetary implications as noted below.** Collecting "recovery support" (e.g., transportation, housing, and other basic needs) services data on individuals would be valuable in assessing the effectiveness of those services. The Department currently does collect information on use of DMHAS-subsidized "recovery supports" through its federally supported Access to Recovery (ATR) I and II grants and the state-funded GABHP Recovery Support Program. Both of these recovery initiatives have clearly demonstrated the efficacy and value-added effects of recovery support services linked to traditional clinical interventions. This type of information, coupled with available treatment service performance outcomes, can and will be used increasingly to assess the effect of recovery supports on individual outcomes. Several next steps by DMHAS may well be needed, and are under consideration, prior to fully adopting this recommendation as a core outcome measure for provider agencies and/or the DMHAS system. The degree of infrastructure expansion within DMHAS' quality analysis and information systems has not yet been determined; it may be appreciable. At the same time, there is no reason why DMHAS cannot build on and use existing procedures and analyses developed through its ATR and GABHP recovery support experiences.

- **<u>Recommendation 15:</u> DMHAS shall develop a strategy to encourage the development of licensed or credentialed staff in providing clinical services among all funded and state-operated substance**

abuse treatment providers. Such strategy shall consider a long-term phase-in of such a requirement. The strategy shall be developed by January 1, 2010.

DMHAS **agrees with the intent of the recommendation, with service system experience and budgetary reservations as noted below.** Conceptually, the Department understands the importance of having licensed or credentialed clinical staff providing treatment in certain levels of care, and our current policies reflect the program licensing requirements established in DPH regulations. For example, throughout the GA Behavioral Health Program policies and draft regulations, language is written requiring certification or licensure for key staff in all levels of care. Without such licensure or certification, staff is either ineligible, or required, to meet other strict guidelines for provision of certain services to clients. In addition, the Department, through the Office of Multicultural Affairs conducts the PACTT program which is geared to providing training and internships that prepare individuals to eventually become 'certified' as drug and alcohol counselors.

However, one of the most striking and unquestioned findings from the DMHAS GA Behavioral Health Program and ATR grants is the extraordinarily effective role that persons in recovery, recovery specialists or other types of peers can play as intensive care managers for persons with repetitive high use of costly acute care services. Properly trained and supervised, peer specialists have dramatically decreased the costly patterns of acute care services and linked over 2,000 clients to more effective, less costly and sustained routes of recovery. Literally, millions of dollars in costs have been either saved or reinvested so that more people were able to be treated, with better outcomes and at a lower cost per person. Formal training programs and curricula have been developed and are being offered so that "certification" or "credentialing" can be achieved. Similar patterns are being followed in mental health services, including being able to obtain Medicaid reimbursement for such certified peer specialists.

While implementation of this recommendation for both licensed/credentialed clinical staff, and separately for peer specialists, would likely result in **significant costs to DMHAS as well as to its funded providers, the enhanced quality outcomes and cost offsets (especially due to the use of peers) would be well worth it.**. DMHAS suggests including its current strategies for encouraging the development of these two categories of staff within the proposed Substance Abuse Strategic Plan (see **Recommendation #23**).

- <u>Recommendation 16:</u> **DMHAS shall compile a profile of each SA treatment provider that receives state funding. This provider profile shall be updated on an annual basis and be maintained on the department's website. The profile shall include: client populations served; language competence of staff; types of care available and the number served at each level of care; extent to which services are evidence-based or not; accreditation status of the provider; client survey results; the percent of employees who are licensed or credentialed who perform assessment, treatment plan development, and treatment delivery services; and treatment completion rates by level of service, average wait times for treatment services, and outcome information, including the federally required National Outcome Measurement System data, and any other information DMHAS deems relevant.**

DMHAS **agrees with the intent of the recommendation; implementation as recommended has a fiscal implication as noted below.** As mentioned in the DMHAS response to Recommendation #2, the Department produces a service directory of behavioral health provider agencies that contains some (client population served, types of services) of the recommended information. DMHAS is in the process of developing a Provider Report Card which would contain much of the additional information recommended. This information, along with the service directory, could be made available to the public both in hard copy and electronically via the Internet. Some information suggested— such as the percent of employees who are licensed or credentialed who perform assessment, treatment plan development, and treatment delivery services — would require that new data be collected from providers. The fiscal implications for the provider to submit such data and for DMHAS to track it should not be significant.

- **Recommendation 18: DMHAS, in conjunction with CSSD, should conduct an evaluation of the effectiveness of PAES and PDEP in terms of their impact on participant substance use and criminal justice involvement. The agencies should also develop outcome measures for both programs that are reported, at a minimum, in DMHAS' biennial report, beginning in 2010.**

DMHAS **agrees with the intent of the recommendation, with the fiscal note listed below.** A recidivism study of persons completing PAES or PDEP would be helpful in determining the efficacy of these programs, as well as in terms of increasing program effectiveness by informing meaningful changes, and providing valuable data useful for the development of public policy relevant for both criminal justice and treatment approaches. In order to implement this recommendation, service records for the PAES and PDEP program would need to be matched to driver license records, following completion of the PAES or PDEP program. Practically, this would require a Memorandum of Agreement between the Judicial Branch and DMHAS to allow for access to arrest and PAES/PDEP records. **Additional staff resources for the data matching, evaluation, design, and data analysis would be needed in order to successfully accomplish this.**

- **Recommendation 19: DMHAS should develop and review the performance and outcome information related to the state's methadone maintenance and other opioid replacement treatment programs by July 1, 2010. The information should be summarized and reported on the agency's website and the department's biennial report. At a minimum, it should include how long people remain in treatment, whether providers are in compliance with all state and federal standards, and what improvements clients have experienced in their substance use and quality of life because of the treatment they received.**

The Department **agrees with the intent of the recommendation, with an implementation qualification and fiscal note described below.** DMHAS is currently evaluating the performance and outcome information related to the state's methadone maintenance and other opioid replacement treatment programs. Performance and outcome data for methadone maintenance providers are distributed routinely to providers on a monthly basis through the EQMI Monthly Performance Reports. These reports include the standard National Outcome Measures (NOMS) and evaluate clients' changes in status in criminal justice involvement, homelessness, substance use, and employment from the time of admission to discharge. Also, DMHAS is able to report on the length of time a person is involved in methadone treatment.

As persons in methadone maintenance may remain in treatment for a long period of time, and appropriately so, one limitation of the current data collection process is the reporting of selected indicators only at the time of admission and discharge. Currently, DMHAS does not require periodic updates during treatment, which would permit measuring performance at intervals (i.e., 3 months, 6 months, one year). In order to remedy this issue, DMHAS is exploring the possibility of implementing either a point-in-time approach or requiring providers to collect and report status updates at selected intervals during the year. The single point-in-time, per year, approach may not be too onerous and fiscally demanding; However, moving to a few such periodic reports on selected client indicators during the year will lead to **a substantial increase in resource requirements for DMHAS and the providers involved. A cost-contained pilot approach may work best as a start.**

Regarding compliance with federal standards, providers of methadone maintenance treatment are required to be accredited by a national accrediting body, certified by the federal Center for Substance Abuse Treatment (CSAT) and licensed by DPH. DMHAS, as the State Methadone Authority, coordinates with CSAT for the initial establishment and ongoing operation of these programs, by either approving or denying their operation within the state of Connecticut, whether or not they receive state funding. DPH routinely informs DMHAS of any licensing violations that pertain to providers.

- **Recommendation 21: DMHAS, as the lead state substance abuse agency, should expand and strengthen its role in developing, gathering, analyzing, and reporting outcome measures regarding**

the effectiveness of the state's substance abuse treatment system.

The Department **supports** this recommendation. DMHAS continually strives to improve the quality of its service system. Performance monitoring is a critical component of these system-wide efforts. Over the past three years, substantial progress has been made in the areas of data quality, reporting, and evaluation and analysis. Our EQMI Division has completed data quality visits to all providers and is now embarking on a second phase of "targeted data quality visits" which are focused on a small subset of providers that continue to have serious data issues. EQMI has continued bi-monthly provider data quality calls which are used to address data reporting issues. Other changes are being instituted, such as a new data quality tracking system, provider training, and enhanced reporting. Many of these changes are already underway, using existing staff resources. In addition, the Commissioner has convened a Quality Information Work Group which is comprised of representatives from Evaluation Quality Management and Information, Planning, Information Systems, and Health Care Systems. This work group is focusing on improving data quality, analysis, and reporting, and has initiated a range of activities focused on data clean-up, standardized reporting, and inter-departmental coordination. (See Recommendation #31 for related comments.)

- **Recommendation 23: Current statutory provisions for a statewide substance abuse plan shall be repealed and replaced with a requirement for a strategic planning process for the state substance abuse treatment system for adults that is overseen by DMHAS. Beginning in 2009, the department shall prepare and annually update a three-year strategic plan for providing treatment and recovery support services to adults with substance use disorders. The plan shall be based on a mission statement, a vision statement, and goals for the state treatment system, including all state-funded and state-operated services that are developed by DMHAS, in consultation with its regional action councils, consumers, and their families representing all client populations including those involved in the criminal justice system, treatment providers, and other stakeholders. The strategic state substance abuse plan shall outline the action steps, timeframe, and resources needed to address the goals developed with stakeholders.**

The Department **supports** PRI's recommendation that it would be beneficial to create a three-year Substance Abuse Strategic Plan that is updated annually. Currently, DMHAS facilitates substance abuse strategic planning through its administrative units— including the EQMI Division, Office of Program Analysis and Support, and Health Care Systems. Additionally other structures, such as the DMHAS Managed Care Steering Committee and the Alcohol and Drug Policy Council, provide the Department with a strategic vision for policy and program development. Under the direction of the Commissioner's Strategy, Analysis and Implementation Group established in April 2008, DMHAS will incorporate these internal and external resources into a comprehensive strategic planning process.

DMHAS will engage in an internal process to determine the scope of the initial substance abuse strategic plan that draws upon its current efforts at determining the most effective and efficient approaches to serving those in need of addiction services. Current efforts include:

a. The **Priority Services Setting Process** designed to determine unmet needs and identify emerging issues through broad local stakeholder input on service priorities, needs, and solutions.
b. Analysis of environmental factors through its **State Epidemiological Workgroup** charged with reviewing substance abuse consumption and related consequence community indicators and promoting cross-agency data sharing in support of analytic studies.
c. Trends analysis as to client outcomes, alcohol and drug use characteristics, and service access by critical populations as is currently part of DMHAS' statutory requirement and part of its **biennial report** on substance abuse programs to the legislature.
d. Policy development that addresses emerging issues identified through the **State Board of Mental Health and Addiction Services, the Alcohol and Drug Policy Council, the Criminal Justice Policy Advisory Committee** and other such advisory bodies.

- **Recommendation 24: Provisions of the community re-entry strategy developed by the Criminal Justice Policy and Planning Division regarding substance abuse treatment and recovery services needs of the offender population shall be incorporated within the state strategic plan.**

DMHAS **supports** this recommendation and agrees that provisions of the community re-entry strategy developed by the Criminal Justice Policy Advisory Committee (CJPAC) regarding substance abuse treatment and recovery services needs of offender populations be incorporated within the Substance Abuse Strategic Plan (Recommendation #23). DMHAS Forensic Division staff are active members of the CJPAC and work collaboratively with CSSD, DOC's Addiction Services Division, and the Board of Pardons and Parole, as well as representatives of private nonprofit providers of adult substance abuse treatment services to develop goals related to treatment and recovery support service needs of adults with substance use disorders who are involved in the criminal justice system.

- **Recommendation 25: DMHAS shall conduct a financial viability assessment of its private provider network. This assessment should estimate the extent to which the community providers have the ability to appropriately meet their clients' needs and their mission in a sustainable way over the next five to ten years.**

As described, DMHAS **does not support** this recommendation, as there are several methods the Department currently uses to determine financial viability within its provider network. DMHAS reviews each private non-profit provider's contract for fiscal viability on an annual basis. There are three mechanisms and points in time when fiscal reports are required for monitoring the contract budget: the Eight-Month Internal Fiscal Report; the Annual Financial Report; and the provider's annual State Single Audit report.

The Eight-Month Interim Fiscal Report covers the period July 1 through February 28th and provides a means for DMHAS to monitor a program's fiscal status prior to the end of the state fiscal year. At that time, DMHAS monitors the degree to which the contractor's actual income and expenses for each funded program is consistent with the approved contract budget. The Annual Financial Report is submitted by September 30th after the close of the previous fiscal contract year. This report provides detailed final figures on income and expenses by program for the state fiscal year which ended the previous June 30th. While these two reports focus mainly on the viability of a DMHAS contracted program, the State Single Audit looks at the entire fiscal position of the agency. All recipients of state funds are subject to the requirements of the State Single Audit ACT (SSAA). Private nonprofit providers are required to undergo a state single audit or program-specific audit if the provider expends more than $100,000 of state funds in a fiscal year. Additionally, this report identifies those agencies having fiscal difficulties and affords an opportunity for the Department and the provider agency to develop corrective actions plans.

If this recommendation were to be effectively and appropriately accomplished, there must first be a definition of the term "network," as DMHAS does not currently fund individual or designated networks of providers. Second, such a survey must require that a provider identify all sources of public and private revenues, income and expenses— both for its core or service agency, and for any collateral or related components, such as real estate holding or associated legal entities. Relative to personnel costs, the summary must designate salary, as well as special or deferred compensation plans, for all or some employees. Third, the duration should be no longer than 3 - 5 years. Fourth, the Commissioner should have the right to assess financial viability, not only for individual agencies, but also for groups of agencies within different geographical areas of his/her choosing. Finally, such an analysis must have the benefit of an external financial consultant who could assist in framing out the design and analytic procedures to effectively achieve the goals of the study.

- **Recommendation 26: The statutes shall be amended to establish clearly that DMHAS is the state lead agency for substance abuse.**

DMHAS **supports** this recommendation as it affirms the Department's current responsibilities and practices. As noted in the PRI study, the Connecticut General Statutes establish DMHAS' authority regarding the planning, coordination, delivery, and monitoring of alcohol and drug treatment for adults and require the Department to establish uniform policies and procedures for the collection of data related to substance use, abuse, and addiction programs across state-funded and operated services. DMHAS has been designated by the Governor as the Single State Agency for the application and receipt of the federal Substance Abuse Prevention and Treatment Block Grant. Recognizing these responsibilities and others codified in state law, it is clear that DMHAS is the state lead agency for matters concerning substance abuse services for adults.

- Recommendation 27: **DMHAS should create and lead an interagency workgroup, composed of its own staff responsible for fiscal, contracting, and provider monitoring functions, as well as staff from other state agencies that fund and/or oversee substance abuse treatment services, including CSSD, DOC, and DPH, to study and address such matters as: rules and regulations that are at odds with best care practices (e.g., appointments on separate days) and needless duplication of effort (e.g. repetitive financial forms); a standard plan of care so no matter what "door" a person comes in for treatment, there will be a consistent approach to developing the care plan; each plan will address a full continuum of services (from detoxification, if needed, to aftercare) and it should follow the client through the publicly funded system; better sharing of data, including regular distribution of DMHAS monthly and semi annual provider performance reports and profiles to CSSD and DOC; and ways to track and report on connection to services and treatment outcomes for DOC and CSSD clients with substance use disorders following discharge from the criminal justice system.**

The Department **agrees with the intent of the recommendation; however, its implementation as recommended has appreciable budgetary implications.** Currently, there are several cross-state-agency (including the Judicial Branch) collaborative groups whose aim is to provide better coordination of state-funded treatment services. As mentioned in the PRI study, one of these is the Collaborative Contracting initiative, which provides a model for other possible collaborative efforts aimed at streamlining contracting, monitoring and other administrative functions. The following provides some thoughts on the PRI recommendation which covers a broad range of service coordination and administrative responsibilities.

a. DMHAS agrees that there exist specific, identifiable conflicts between best practices and multiple state agency rules and regulations that create barriers. An effective process to resolve these barriers requires an inclusive process of not only state agencies, but also private providers who are best able to identify the areas of conflict. Recent examples of reaching similar solutions have been effective, providing a precedent for this process.

b. The suggestion of a standardized care plan that follows the client through the publicly funded system is a sensible one that would likely result in better coordination of care, and possibly improved quality of client care. The practicality of such implementation faces impressive challenges, including but not limited to: confidentiality regulations, licensing and accreditation standards, autonomous agency (including proprietary) instrumentation and processes, among others. The **cost implication to providers** to move to one standardized care plan could result in **significant costs,** including the need for staff training and retooling of current information systems.

c. DMHAS can produce performance reports for DOC-operated and CSSD-funded treatment facilities. This information will be provided through the Monthly Performance Reports distribution system.

d. Tracking individuals released from the criminal justice system (i.e., prison inmates, probationers or

parolees) as to their continued treatment in the community and related outcomes is possible, using linked data sets across the DOC, CSSD and DMHAS information systems. While this method has been used in limited fashion in the past, **it would require modest resources in order to link the data sets and conduct the analysis.**

- **Recommendation 28: DMHAS should begin working closely with the Department of Public Health to have updated substance abuse treatment regulations and the new, combined license for dual behavioral health care providers in place by July 1, 2010.**

DMHAS **supports** this recommendation, as there is a process currently in place to accomplish it. In the spring of 2008, DMHAS, the Department of Public Health (DPH), and service provider representatives from the Connecticut Community Provider Association (CCPA) and the Connecticut Association for Nonprofits (CAN) completed a thorough review of Sec. 19a-495-570 (*Licensure of freestanding facilities for the care of substance abusive or dependent persons*) and Sec. 19a-495-550 (*Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults*) of the C.G.S. with the intent of drafting a new, combined license for dual behavioral health care. DPH is in the process of writing the new regulations, with a first draft anticipated soon.

- **Recommendation 29: The department should also conduct, with assistance from DOC and CSSD, a formal analysis of the costs and benefits of the collaborative contracting project to determine its impact on: standardizing rates paid by participating agencies; reducing administrative expenses of providers; and improving access to, and utilization of, available residential treatment resources.**

DMHAS **agrees with the intent of the recommendation, with a fiscal note listed below.** The Department recognizes the value of conducting an evaluation of the impact of the collaborative contracting project. While a simple analysis could be conducted with added administrative personnel efforts, a more comprehensive evaluation would require **additional resources and expertise.** As a first step, DMHAS suggests that a determination be made concerning the resources that would be needed and whether these resources may be obtained to conduct a formal evaluation.

- **Recommendation 30: DMHAS should restructure its existing staff resources allocated to planning, monitoring, and evaluation to create a centralized unit responsible for comprehensive strategic planning and quality improvement. It should also serve as the department's best practices unit, identifying effective treatment approaches and performing a clearinghouse function on policies, programs, and activities followed by Connecticut programs with good outcomes. Further, it should be a central repository for all state agency internal and external research products on treatment effectiveness.**

The Department **does not support** this recommendation, as we believe that our current organizational structure does fulfill the functions stated in the recommendation. However, DMHAS will explore the formation of a standing Quality Improvement and Planning Committee that will function as a subcommittee of the Commissioner's Strategy, Analysis and Implementation Group established April 2008. The Quality Improvement and Planning Committee will be charged with the development, implementation, monitoring, and reporting of a comprehensive three-year strategic plan (see Recommendation #24). The committee's charge will include reviewing best practices, identifying effective treatment approaches and evaluating policies, programs, and activities as part of the strategic planning process.

- **<u>Recommendation 31:</u> DMHAS shall prepare a "report card" for the publicly funded substance abuse treatment system that addresses, but is not limited to, the following areas: access to treatment; quality and appropriateness of treatment; treatment outcomes, including measures of abstinence and reduced substance use, as well as quality of life improvements related to employment, living arrangement, criminal justice involvement, and family and community support; and client satisfaction. At a minimum, the report card should be posted on the agency website and included in the biennial report.**

The Department **supports** this recommendation. Currently, results of the 28-item "*Annual Consumer Survey*" for each DMHAS-funded provider are published on the agency's website. The survey addresses access, appropriateness, general satisfaction, participation in treatment, and recovery. Specific levels of consumer satisfaction are required per contract for each provider.

As of July 2009, the Department will begin to post on its website annual outcome measures for individual agencies and levels of care based on its now 9-year experience with the General Assistance Behavioral Health Program. The measures will include Connect to Care within 30, 60 and 90 days; and readmission into the same or higher level of care within 30, 60 or 90 days. Other relevant data will also be included in the posted report.

See also the DMHAS response to **Recommendation #16**. The report card will be combined with the Provider Profile described in that section.

Conclusion:

Based upon the Department's response, it is clear to see that DMHAS is actively pursuing ways to enhance its delivery of efficient, effective, and quality care for persons with substance use disorders. This involves strengthening internal structures, procedures, and policies, as well as promoting even greater collaboration among its partners. As consequences of substance misuse and abuse cut across every segment of the public service sector, great gains can be realized in providing the very best care possible — i.e., care that is based upon proven approaches that produce desired results.

In the coming year, the Department is committed to continuing to enhance treatment access, service quality and overall accountability of the DMHAS substance abuse treatment system. This can be seen in the Department's response to the PRI recommendations. For instance, treatment access will be better managed by introduction of a time-to-treatment service measure. This tool will promote improvements in treatment programs, making them more responsive to the individuals seeking treatment and to their needs. Enhancing service quality is, without a doubt, a continuous process. DMHAS' focus on evidence-based practices and treatment therapies with proven results will continue, with renewed energy and commitment. Certainly, the value or "return on investment" of any service must be measured in tangible results. The Department's implementation of a provider "report card" will be the cornerstone for measuring the value of services and assuring accountability. There are other examples throughout the Department's response to the PRI recommendations that resonate with the DMHAS core strategic vision. Practically speaking, some of those do have cost implications which must be carefully weighed in consideration of the current economy.

STATE OF CONNECTICUT
JUDICIAL BRANCH

CHAMBERS OF
BARBARA M. QUINN, JUDGE
CHIEF COURT ADMINISTRATOR

231 CAPITOL AVENUE
HARTFORD, CT 06106

April 16, 2009

Carrie E. Vibert, Esq.
Director
Legislative Program Review and Investigations Committee
State Capitol - Room 506
Hartford, Connecticut 06106

Dear Attorney Vibert,

Thank you for providing the Judicial Branch with an opportunity to review the draft copy of the final report on *Substance Abuse Treatment for Adults*. Please find the attached document which details the responses and clarifications of the information applicable to the Court Support Services Division. All of the responses are related to Chapter VI: Program Monitoring and Treatment Quality, and specifically address either a finding or recommendation.

If there are any questions or additional inquiry necessary, please contact Stephen Grant, Director - Court Support Services Division at (860) 721-2100.

Sincerely yours,

Barbara M. Quinn
Chief Court Administrator

BMQ:maf
Attachment

TELEPHONE: (860) 757-2100 FAX: (860) 757-2130 E-MAIL ADDRESS: BARBARA.QUINN@JUD.CT.GOV

JUDICIAL BRANCH-COURT SUPPORT SERVICES DIVISION
RESPONSE TO
LEGISLATIVE PROGRAM REVIEW & INVESTIGATIONS COMMITTEE
DECEMBER 2008 REPORT
SUBSTANCE ABUSE TREATMENT FOR ADULTS

CHAPTER VI: PROGRAM MONITORING AND TREATMENT QUALITY

A) PROGRAM MONITORING AND QUALITY ASSURANCE

- **Efforts to check fidelity are very limited, except in one agency. DOC checks for program fidelity for all of its in-facility programs and CSSD is checking program fidelity for three of its 23 program models. The other agencies do not require program fidelity checks and, if performed, are done so sporadically.**
    - **RESPONSE: The Judicial Branch's Court Support Services Division (CSSD) provides comprehensive quality assurance activities to ensure fidelity and integrity in the delivery of 15 different services in 19 locations and 3 of its program models. Due to current fiscal and/or administrative constraints, CSSD does not currently provide quality assurance activities of all of its program models. However, many of the programs that CSSD does not quality assure have contractual oversight by another agency or CSSD funds a portion of the delivery of services.**

- **DMHAS should investigate, with CSSD, the DOC parole division, and DPH, the development of joint quality assurance and monitoring teams for substance abuse treatment facilities.**
    - **RESPONSE: This presumes that the services meet the specialized needs of the criminal justice populations served; common measures would need to be developed, standards, tools etc. as part of this process.**

- **CSSD should expand its quality assurance process to include its other program models that contain a substance abuse treatment component.**
    - **RESPONSE: There are programs such as Adult Behavioral Health (ABH) and residential treatment in which CSSD does not "own" the program model; clinical supervision exists for treatment staff but QA of various group interventions (that include non-CSSD client participants) presents challenges.**

B) SELECTED BEST PRACTICES

- **DOC and CSSD shall ensure that all substance abuse treatment providers are properly licensed as required by law.**
    - **RESPONSE: Those who provide treatment (ABH/Residential treatment) are licensed; there are significant resource/funding implications for other programs such as Juvenile Risk Reduction Centers (JRRC- 16/17 year olds)/ Alternative Incarceration Centers (AIC), as these**

programs are not clinical and do not provide treatment but rather substance abuse education services.

C) OUTCOME AND PERFORMANCE MEASURES

- Completion rate data available for only one of CSSD's programs and no DOC parole programs.
    - RESPONSE: Completion rates are calculated for all CSSD-contracted programs. Seventeen (17) AIC's and one Adult Risk Reduction Center submit data on all curricula via the Contractor Data Collection System (CDCS); all other programs submit program completion data via a monthly paper-based report. We expect that all CSSD-contracted programs will be entering data in the CDCS by the end of 2010.

- Together, DMHAS and CSSD operate two drug and alcohol education diversion programs for certain first time offenders. Although they serve over 12,500 individuals a year, the programs have not been formally evaluated.
    - RESPONSE: In the pre-trial drug / alcohol education diversionary programs CSSD is responsible for: completing diversionary program application paperwork, conducting background checks to ensure referrals meet statutory eligibility criteria for diversionary program (i.e. defendant has not used this program before), making referrals to substance abuse education program and community service as required based on where the client lives or can access services and collect treatment and community service reports from contracted providers, and have them available to court prior to a defendant's court appearance.

      CSSD does not provide or contract with any providers for the drug and/ or alcohol education services. These services are contracted by DMHAS. CSSD staff complete all applications, background checks, referrals to contracted providers and forwards all paperwork to the court prior to the defendant's court date.

- There is no consistent, on-going check of those participating in particular programs and recidivism, though CSSD is in the process of developing this capability.
    - RESPONSE: CSSD has begun tracking recidivism rates for clients engaged in services at the Alternative Incarceration Centers and the Adult Risk Reduction Center. Though current analysis is ad-hoc, a standardized system of tracking and benchmarking recidivism rates for participants in specific services will be introduced in Spring 2009. CSSD is also involved in a three-year evaluation being conducted by the National Institute of Corrections of the Women Offender Case Management Model.

- CSSD and DOC should calculate completion rates for those clients enrolled in their substance abuse treatment programs. CSSD and DOC should benchmark their completion rates against programs offered by other similar criminal justice and correctional agencies.
    - RESPONSE: Completion rates are calculated for all CSSD-contracted programs. Seventeen (17) AIC's and one Adult Risk Reduction Center submit data on all curricula via the Contractor Data Collection System (CDCS); all other programs submit program completion

data via a monthly paper-based report. We expect that all CSSD-contracted programs will be entering data in the CDCS by the end of 2010. A benchmarks project is currently underway in CSSD and will be introduced in a phased process in 2009.

- **DMHAS, in conjunction with CSSD, should conduct an evaluation of the effectiveness of PAES and PDEP in terms of their impact on participant substance use and criminal justice involvement. The agencies should also develop outcome measures for both programs that are reported, at a minimum, in DMHAS' biennial report, beginning in 2010.**
    - **RESPONSE: Initial discussions around the evaluation of these programs have occurred between the research units at CSSD and DMHAS. CSSD will provide court and recidivism data and DMHAS will be the lead agency in the treatment data analysis.**

D) MONITORING & EVALUATION RESOURCES & DATA SYSTEMS

- **CSSD has 17 staff dedicated to performing contract compliance activities and another 17 employees who staff two separate offices dedicated to best practices and quality assurance.**
    - **RESPONSE: CSSD Grants and Contracts unit has twelve staff performing state-wide adult and juvenile contract compliance activities (Compliance Specialists and Court Planners). Six of the nine staff in the Center for Research, Program Analysis and Quality Improvement are dedicated to research, data analysis, evaluation and quality assurance of CSSD operational and programmatic initiatives. Eight Programs and Services/CBP staff are dedicated to research, design, implementation and quality assurance of statewide adult and juvenile initiatives and contracted services.**

STATE OF CONNECTICUT

DEPARTMENT OF CORRECTION
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Theresa C. Lantz
Commissioner

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April 22, 2009

Carrie E. Vibert, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Ms. Vibert:

Thank you for the opportunity to formally respond to the Committee's final report, *State Substance Abuse Treatment for Adults*. While the Department of Correction (DOC) finds that the report is an objective, unbiased analysis of the agency's substance abuse treatment systems within its facilities and the Parole and Community Services Division, I believe it is important to respond to some of the Committee's conclusions and recommendations.

Recommendation four states that "the DOC should assess the costs and operational implications of transferring counselors in the community to DOC facilities to expand intensive outpatient and residential treatment offerings in DOC facilities; and, in the absence of transferring community counselors, assess the cost savings that may result in treating additional inmates in DOC facilities rather than in residential treatment in the community while on parole." The Community Addiction Services Program is currently being reviewed to consider the reallocation of staff resources. Considerations include the cost effectiveness of in-facility treatment and the larger population to be served by moving staff from community to facility-based programming.

Recommendation five states that the Parole and Community Services Division "should include a periodic audit check of its contracted providers to improve its contract monitoring practice and quality assurance processes to ensure that that contracts requirements are being met and services are being delivered appropriately." The Parole and Community Services Division has developed a comprehensive Residential and Non Residential Audit Form. In order to fully comply with this recommendation, the DOC would require additional staff to review compliance with contractual requirements but understands the reality of the state's fiscal climate.

Recommendation eight states that the "Court Support Services Division (CSSD) should further develop, and the DOC Parole and Community Services Division should consider developing, a quality assurance process that assesses the work of probation and parole officers with regard to core practices that assist in reducing criminal behavior and enhancing offender motivation to change, especially for those offenders with a substance abuse problem." Before the Parole and Community Services Division can fully implement this recommendation, the DOC believes the staff should receive training in motivational interviewing. Parole officers should also receive training in therapeutic alliances, short-term client systems, recovery model, cognitive behavioral therapy and other treatment modalities.

Recommendation twelve states that the DOC Parole and Community Services Division "should ensure that all treatment information is considered when referring clients for additional substance abuse treatment, including the treatment received while in DOC facilities and any discharge planning developed by the Addiction Services Unit. The Division should ensure that all referrals to residential treatment are appropriately made." Substance abuse treatment information is available to enhance the decision-making by the facility administrator and/or the Parole Liaison Officer prior to the offender's release to parole or Transitional Supervision. Counselors are available to assist the Residential Parole Manager in the proper clinical selection of inmates for residential substance abuse treatment beds.

Recommendation fourteen states that "DOC and CSSD shall ensure that all substance treatment providers are properly licensed as required by law." For future Requests for Proposals, the DOC will consider the licensure of all substance abuse treatment providers.

Recommendation sixteen states that the Department of Mental Health and Addiction Services and the DOC "shall compile a profile of each substance abuse provider that receives states funding" and provide more specific information about client population, staff and wait times and completion rates. The DOC currently has a 125-page directory of contracted services that is available on its website. This detailed document has received commendation from the general public, the legislature and the media, and is used by clients and families of offenders for descriptions and locations of services. The directory can be expanded to include the profile of information recommended by the Committee. The DOC also has a compendium of services provided within its facilities.

Recommendation twenty-two states that the DOC "should conduct an assessment of its management information system to determine how it could better meet its research and management needs." A project has been initiated to replace the agency's 45 year old outdated internal information system. The current system contains a broad array of current and historical offender information, but lacks the capacity to easily provide basic management statistics. It has frustrated our efforts to provide critical data to a variety of internal and external consumers, including members of the legislature.

With regard to Outcome and Performance Measures, the Committee recommends that "CSSD and the DOC calculate completion rates for those clients enrolled in their programs… and benchmark their completion rates against programs offered by other similar criminal justice and correctional agencies." The Committee further recommends that the DOC "evaluate whether its contracted community private providers produced better completion rates and outcomes than offenders on parole and receiving services from DOC." The DOC does calculate completion rates on all of its programs. Currently, the Association of State Correctional Administrators is working on the development of a Performance Based Measurement System to provide comparative data among correctional agencies in member states.

I again thank the Committee staff for the opportunity to review and comment on this comprehensive report. I am confident that it will serve to improve substance abuse treatment within the Department of Correction system. The DOC will attempt to implement the recommendations within existing resources, which are now particularly stretched in both the Addiction Services facility programs and parole treatment.

Sincerely,

Theresa C. Lantz
Commissioner